Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for a Renewal to a §1915(c) Home and Community-Based Services Waiver

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:
•Added Healthcare for Workers with Disabilities as an eligibility group

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

A. The **State** of **Washington** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. **Program Title** (*optional - this title will be used to locate this waiver in the finder*):
New Freedom renewal 2010

C. **Type of Request: renewal**

☐ **Migration Waiver** - this is an existing approved waiver

☑ **Renewal of Waiver:**

Provide the information about the original waiver being renewed

Base Waiver Number: 0443

Amendment Number (if applicable):

Effective Date: *(mm/dd/yy)*

Waiver Number: WA.0443.R01.00
Draft ID: WA.15.01.00

Renewal Number: 01

D. **Type of Waiver** *(select only one)*:
Regular Waiver

E. **Proposed Effective Date:** *(mm/dd/yy)*
02/15/10

Approved Effective Date: 02/15/10

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan (*check each that applies*):

☐ **Hospital**

Select applicable level of care

○ **Hospital as defined in 42 CFR §440.10**

If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☑ **Nursing Facility**

Select applicable level of care

◉ **Nursing Facility As defined in 42 CFR §440.40 and 42 CFR §440.155**

If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:

○ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

☐ **Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150)**

If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/MR level of care:

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

◉ **Not applicable**

○ **Applicable**

Check the applicable authority or authorities:

☐ **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**

☐ **Waiver(s) authorized under §1915(b) of the Act.**

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

Specify the §1915(b) authorities under which this program operates *(check each that applies):*

☐ **§1915(b)(1) (mandated enrollment to managed care)**

☐ **§1915(b)(2) (central broker)**

☐ **§1915(b)(3) (employ cost savings to furnish additional services)**

☐ **§1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program operated under §1932(a) of the Act.**

Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

☐ **A program authorized under §1915(i) of the Act.**

☐ **A program authorized under §1915(j) of the Act.**

☐ **A program authorized under §1115 of the Act.**

Specify the program:

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.
As an important element of the State's commitment to provide community alternatives to institutional care, New Freedom provides participant directed services to adults who are eligible for nursing facility level of care. The New Freedom waiver offers participants the opportunity for full participant direction. Participants select the services they need, when those services are provided, who will provide the services, and how they will be delivered. Participants have flexibility to plan and purchase goods and services specific to their unique needs and preferences.

The state uses the automated comprehensive assessment, CARE, to gather information about the participant's strengths, functional abilities, preferences and limitations. The assessment is completed by the contracted case management entity, a local/regional non-governmental, non-state entity. When the assessment has been completed, this information is used to compute an individualized monthly budget based on the unmet needs of the waiver participant and valued at the hourly rate for in-home personal care.

New Freedom participants meet with a New Freedom consultant to prepare a Participant Centered Spending Plan (PCSP) for the budget allowance which can include a range of choices beyond one on one personal care. Consultants facilitate planning at the direction of the participant and/or the participant's representative. Consultant Support Services are provided through contract with the SMA.

Financial Management Services (FMS) are provided to manage the budget allowance and associated responsibilities such as payroll and withholding. FMS contracts with qualified providers to deliver the services identified in the PCSP. The FMS also ensures that expenditures are in keeping with the participant's service plan. Financial Management Services are provided through contract with the SMA.

The new Freedom waiver is currently available only in King County. The State intends to add additional location(s) within the next two years through the waiver ammendment process.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. Waiver Administration and Operation. Appendix A specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. Appendix D specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- (•) **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ( ) **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

F. Participant Rights. Appendix F specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. Appendix G describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Improvement Strategy. Appendix H contains the Quality Improvement Strategy for this waiver.

I. Financial Accountability. Appendix I describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. Appendix J contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

- (•) **Not Applicable**
- ( ) **No**
- ( ) **Yes**

C. Statewideness. Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

- ( ) **No**
- (•) **Yes**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

- [x] **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State. *Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:*
  Available only in King County
- [ ] **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.
  Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

A. Health & Welfare: The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR §441.301(b)(1) (ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/MR.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community- based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Improvement. The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the

Quality Improvement Strategy specified in **Appendix H**.

I. Public Input. Describe how the State secures public input into the development of the waiver:
During the development and piloting of the New Freedom waiver, the state established and supported a standing stakeholder advisory group comprised of people who use community based LTC services, case management representatives and labor representation. That group met on a regular basis prior to waiver submission and during initial implementation to offer input and ideas.

In 2008, the Medicaid agency conducted a state wide stakeholder process to obtain information about LTC, HCBS waiver services. Input was obtained from individuals from all areas of Washington State who have a vested interest in the services provided by LTC waivers. Outreach was made to Tribes, individuals using services provided through the waiver, service providers, advocates, and Aging and Disability Services (ADSA) and Area Agencies on Aging (AAA) case management staff. Input on waiver services was primarily gathered through focused group discussions facilitated by ADSA staff. Input was collected from 292 participants attending a total of 16 meetings between May 8 and August 21, 2008.

Input on the New Freedom waiver is also obtained from participant satisfaction surveys. After being on the waiver for 3 months, New Freedom clients receive a customer satisfaction survey from the FMS agency. Customer satisfaction surveys are reviewed quarterly and used to make programmatic changes and service improvements. Customer Satisfaction Survey reports are issued annually.

The State maintains a government to government relationship with the federally recognized Tribes in the state. This includes written accords, a formal process for consultation and process for informal input.

The State routinely secures public input by working closely with the following:
- State Legislature
- Other divisions and state agencies, (Mental Health, Alcohol and Substance Abuse, Vocational Rehabilitation, Department of Health, Medical)

The Medicaid Agency meets with the following to share information and obtain input on program design and quality of care:
- County Coordinators for Human Services
- The Washington Association of Area Agencies on Aging
- Provider associations: Home Care, Home Health, Nursing Facility
- Governor’s Disability Council
- Senior Lobby
- State Council on Aging (Governor's Committee)
- Older Adults Advisory Committee (Mental Health)
- Northwest Justice Project

J. Notice to Tribal Governments. The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name:	Fosbre
First Name:	Marilee

Title:	HCBS Waiver Manager
Agency:	Aging and Disability Services Administration
Address:	PO Box 45600
Address 2:	
City:	Olympia
State:	**Washington**
Zip:	98504-5600
Phone:	(360) 715-2536 **Ext:** ☐ **TTY**
Fax:	(360) 438-8633
E-mail:	fosbrma@dshs.wa.gov

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name:	
First Name:	
Title:	
Agency:	
Address:	
Address 2:	
City:	
State:	**Washington**
Zip:	
Phone:	**Ext:** ☐ **TTY**
Fax:	
E-mail:	

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.
Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature:	Kathy Leitch
	State Medicaid Director or Designee
Submission Date:	Jan 12, 2010

Last Name:	Dreyfus

First Name:	Susan
Title:	Secretary
Agency:	Department of Social and Health Services
Address:	P.O. Box 45010
Address 2:	
City:	Olympia
State:	**Washington**
Zip:	98504-5010
Phone:	(360) 902-7800
Fax:	(360) 902-7848
E-mail:	Susan.Dreyfus@dshs.wa.gov

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

1. **State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):

   - (●) **The waiver is operated by the State Medicaid agency.**

     Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program *(select one)*:

     - ( ) **The Medical Assistance Unit.**

       Specify the unit name:

       (Do not complete item A-2)

     - (●) **Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit.**

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.
Aging and Disability Services Administration
(Complete item A-2-a).

○ **The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency.**

Specify the division/unit name:

In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency. When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:
The New Freedom waiver is administered by the Department of Social and Health Services (DSHS), the Single State Medicaid Agency in Washington State. The Secretary of DSHS is signatory for all aspects of waiver operation including waiver applications, amendments, 372 reports and all other CMS communications. The mechanics of submitting CMS web-based waiver reports and applications have been delegated to the Assistant Secretary for Aging and Disability Services (ADSA)subsequent to the Secretary's approval. The Assistant Secretary for ADSA reports directly to the Secretary of DSHS.

A copy of the DSHS organizational chart is available to CMS.

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.

Appendix A: Waiver Administration and Operation

3. Use of Contracted Entities. Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

● **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*
Consultant Support Services (CSS):
Consultants provide orientation and information to waiver participants about the waiver and how to utilize

services. CSS also provides initial and ongoing support and information to participants about their responsibilities as employers of their Individual Providers of personal care. Consultants assist participants in developing and updating the Participant Centered Spending Plan (PCSP) and obtaining the goods and services identified in the PCSP.

Financial Management Services (FMS):
FMS responsibilities include: accessing the monthly benefit from the Department on behalf of the participant; setting up and managing the participant individual accounts; setting up procedures for verifying qualifications and credentials of providers/service vendors; implementing efficient and timely consumer directed payment systems; facilitating payment for labor, services and other items needed by participants as identified in the PCSP, processing criminal background checks, verifying completion of required training, developing contracts with vendors, and coordinating with the participant's CSS.

- **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

4. **Role of Local/Regional Non-State Entities.** Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

- **Not applicable**
- **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:
  - **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

    Specify the nature of these agencies and complete items A-5 and A-6:

  - **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

    Specify the nature of these entities and complete items A-5 and A-6:

    On-going LOC assessment,eligibility determination and nursing services are provided through contract with a case managment entity. The case management entity is a human service agency with experience and expertise in Service assessment and planning, case management, and service delivery to long term care clients who are aged and/or disabled.

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:
Department of Social and Health Services, Aging and Disability Services Administration

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:
Performance assessment and oversight of non-state entities is performed by the Medicaid agency (ADSA) with methods and frequency as follows:

FMS agency and Assessing entity billings are reviewed on a monthly basis by ADSA program management staff. This includes ensuring that billed services are in accordance with the negotiated contracts. ADSA also monitors monthly to ensure that required staffing ratios are maintained for case management, nursing, and supervisory positions.

Quality monitoring of the local non-state entity is performed on an 18 month review cycle. Level of care evaluations are reviewed for accuracy of eligibility determination and timeliness. The focus of each review cycle is determined by an analysis of the previous year's monitoring results to ensure remediation and improvement. Reviews also focus on ensuring that the CMS protocols are addressed and Washington is in compliance with state and federal regulations. The sample is derived from a randomly selected representative sample of the entire population. A confidence Level of 95 percent with a Confidence interval of +/- 5% is used. To determine the sample size, ADSA uses a validated sample calculator (Raosoft) to determine sample size.

QA monitoring of CSS includes a review of the information that is disseminated to potential waiver enrollees as well as training materials for staff. Monitoring efforts review that services are delivered by qualified providers to recipients as outlined in their Participant Centered Spending Plan (PCSP), that participants have chosen waiver services, have free choice of qualified providers, and that plans are reviewed and updated in a timely manner.

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Contracted Entity	Local Non-State Entity
Participant waiver enrollment	☑	☐	☐
Waiver enrollment managed against approved limits	☑	☐	☐
Waiver expenditures managed against approved levels	☑	☐	☐
Level of care evaluation	☑	☐	☑
Review of Participant service plans	☑	☑	☐
Prior authorization of waiver services	☑	☑	☐
Utilization management	☑	☑	☐
Qualified provider enrollment	☑	☑	☐
Execution of Medicaid provider agreements	☑	☑	☐
Establishment of a statewide rate methodology	☑	☐	☐

Rules, policies, procedures and information development governing the waiver program	☑	☐	☐
Quality assurance and quality improvement activities	☑	☑	☐

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Administrative Authority
The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percent of waiver participants who received a redetermination of LOC by the contracted case management entity within the annual timeframe. N= All waiver participants who received a timely annual redetermination of LOC. D= All waiver participants reviewed.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and**	☐ **Other**

	Ongoing	Specify:
	☑ **Other** Specify: 18 months	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: 18 months

Performance Measure:
Percent of Person Centered Spending Plans (PCSP) completed by consultants for waiver participants that address their assessed needs and personal goals by the provision of waiver services or other means. N=Number of PCSP completed by consultants reviewed that address all assessed needs and personal goals D=Number of PCSP completed by consultants reviewed

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: 24 months	

Data Source (Select one):
Other
If 'Other' is selected, specify:
Administrative Data

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**

☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: 24 months

Performance Measure:
Percent of waiver participant's budgets that monitored by the FMS N= Number of participant budgets monitored each quarter D= Number of waiver participants enrolled for the full quarter

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: 24 months	

Data Source (Select one):
Other
If 'Other' is selected, specify:
Admistrative Data

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**

☐ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: 24 months

Performance Measure:
Percent of records reviewed where services identified in the PCSP are authorized
N=Number of records reviewed where all services identified in the PCSP are authorized
D=Number of records where the PCSP identifies services

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*

☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: 24 months	

Data Source (Select one):
Other
If 'Other' is selected, specify:
Administrative Data

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
The percent of providers determined by the FMS to meet qualifications prior to service authorization N=Number of providers reviewed that FMS determined met provider qualifications D=Number of providers reviewed that FMS contracted

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☑ **Other** Specify: 24 months	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: 24 months

Performance Measure:
Percent of PCSPs where goods and services identified are within the budget allotment. N= PCSPs where goods and services identified are within the budget allotment. D= Number of PCSPs reviewed

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and**	☐ **Other**

	Ongoing	Specify:
	☑ **Other** Specify: 24 months	

Data Source (Select one):
Other
If 'Other' is selected, specify:
Administrative Data

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**

	☐ **Continuously and Ongoing**
	☑ **Other** Specify: 24 months

Performance Measure:
Percent of correctly executed Medicaid provider agreements N: Number of correctly executed Medicaid provider agreements D: Number of provider agreements reviewed

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: 24 months	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

	☐ **Continuously and Ongoing**
	☑ **Other** Specify: 24 months

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
QA and fiscal corrective action plans are required for areas where required proficiency levels are not achieved or if improvement is not evident based upon previous corrective actions. Corrective action plans are evaluated by ADSA prior to ADSA's approval to ensure that plan will effectively address areas of needed improvement. Both the FMS and CSS entities are required to perform discovery and remediation activities. Training elements of corrective action plans are coordinated through ADSA and ADSA staff is made available to provide training and technical support to FMS and CSS staff. The FMS and CSS are required to provide ADSA with an update at six months to report on their progress toward implementing corrective actions.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
QA and fiscal corrective action plans are required for areas where required proficiency levels are not achieved or if improvement is not evident based upon previous corrective actions. Corrective action plans include how individual problems are corrected as they are discovered or within 40 calendar days. Some issues, such as health and safety, require immediate action. Corrective action plans are evaluated by ADSA prior to ADSA's approval to ensure that plan will effectively address areas of needed improvement. Training elements of corrective action plans are coordinated through ADSA and ADSA staff is made available to provide training and technical support to Sunrise staff. Six month update reports on progress made implementing corrective action plans must be provided to ADSA.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: 6 months

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to a group or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one waiver target group, check each of the subgroups in the selected target group that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
○ **Aged or Disabled, or Both - General**					
	☑	**Aged**	65		☑
	☑	**Disabled (Physical)**	18	64	
	☑	**Disabled (Other)**	18	64	
○ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐
○ **Mental Retardation or Developmental Disability, or Both**					
	☐	**Autism**			☐
	☐	**Developmental Disability**			☐
	☐	**Mental Retardation**			☐
○ **Mental Illness**					
	☐	**Mental Illness**			
	☐	**Serious Emotional Disturbance**			

b. Additional Criteria. The State further specifies its target group(s) as follows:

Persons with disabilities may continue to participate in the waiver beyond age 64 as specified in the chart. The waiver is available only to persons who wish to direct their services.

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one):*

○ **Not applicable. There is no maximum age limit**

◉ **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

There is no maximum age limit. Persons with disabilities may continue to participate in the waiver beyond age 64 as specified in the chart.

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)* Please note that a State may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

- (●) **No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c*.
- ( ) **Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c*.

  The limit specified by the State is *(select one)*

  - ( ) **A level higher than 100% of the institutional average.**

    Specify the percentage: [ ]

  - ( ) **Other**

    Specify:

    [ ]

- ( ) **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
- ( ) **Cost Limit Lower Than Institutional Costs.** The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

  Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

  [ ]

  The cost limit specified by the State is *(select one)*:

  - ( ) **The following dollar amount:**

    Specify dollar amount: [ ]

    The dollar amount *(select one)*

Is adjusted each year that the waiver is in effect by applying the following formula:

Specify the formula:

May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.

The following percentage that is less than 100% of the institutional average:

Specify percent:

Other:

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

c. Participant Safeguards. When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant *(check each that applies)*:

The participant is referred to another waiver that can accommodate the individual's needs.

Additional services in excess of the individual cost limit may be authorized.

Specify the procedures for authorizing additional services, including the amount that may be authorized:

Other safeguard(s)

Specify:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

a. **Unduplicated Number of Participants.** The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	800
Year 2	1281
Year 3	2051
Year 4 (renewal only)	3283
Year 5 (renewal only)	5256

b. **Limitation on the Number of Participants Served at Any Point in Time.** Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: *(select one)*:

- (●) **The State does not limit the number of participants that it serves at any point in time during a waiver year.**
- ( ) **The State limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	
Year 4 (renewal only)	
Year 5 (renewal only)	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

c. **Reserved Waiver Capacity.** The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

- (●) **Not applicable. The state does not reserve capacity.**
- ( ) **The State reserves capacity for the following purpose(s).**

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one)*:

- (●) **The waiver is not subject to a phase-in or a phase-out schedule.**
- ( ) **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. Allocation of Waiver Capacity.

Select one:

- (●) **Waiver capacity is allocated/managed on a statewide basis.**
- ( ) **Waiver capacity is allocated to local/regional non-state entities.**

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

The state does not anticipate deferring the entrance of otherwise eligible persons.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

1. **State Classification.** The State is a *(select one)*:
   - (●) **§1634 State**
   - ( ) **SSI Criteria State**
   - ( ) **209(b) State**

2. **Miller Trust State.**
   Indicate whether the State is a Miller Trust State *(select one)*:
   - (●) **No**
   - ( ) **Yes**

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply*:

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

- [x] **Low income families with children as provided in §1931 of the Act**

- [x] **SSI recipients**
- [ ] **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- [ ] **Optional State supplement recipients**
- [ ] **Optional categorically needy aged and/or disabled individuals who have income at:**

Select one:

- ( ) **100% of the Federal poverty level (FPL)**
- ( ) **% of FPL, which is lower than 100% of FPL.**

Specify percentage:

- [ ] **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- [x] **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- [x] **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**
- [ ] **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**
- [ ] **Medically needy in 209(b) States (42 CFR §435.330)**
- [ ] **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**
- [ ] **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

Specify:

Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*

- ( ) **No. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.** *Appendix B-5 is not submitted.*
- (•) **Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

Select one and complete Appendix B-5.

- ( ) **All individuals in the special home and community-based waiver group under 42 CFR §435.217**
- (•) **Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217**

Check each that applies:

- [x] **A special income level equal to:**

Select one:

- (•) **300% of the SSI Federal Benefit Rate (FBR)**
- ( ) **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage:

- **A dollar amount which is lower than 300%.**

Specify dollar amount:

- **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**
- **Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**
- **Medically needy without spend down in 209(b) States (42 CFR §435.330)**
- **Aged and disabled individuals who have income at:**

Select one:

- **100% of FPL**
- **% of FPL, which is lower than 100%.**

Specify percentage amount:

- **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 4)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group. A State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217 *(select one):*

- **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

  In the case of a participant with a community spouse, the State elects to (*select one*):

  - **Use spousal post-eligibility rules under §1924 of the Act.**
    (Complete Item B-5-b (SSI State) and Item B-5-d)
  - **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
    (Complete Item B-5-b (SSI State) . Do not complete Item B-5-d)
- **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.**
  (Complete Item B-5-b (SSI State) . Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 4)

b. Regular Post-Eligibility Treatment of Income: SSI State.

The State uses the post-eligibility rules at 42 CFR 435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

- ○ **The following standard included under the State plan**

  Select one:

  - ○ **SSI standard**
  - ○ **Optional State supplement standard**
  - ○ **Medically needy income standard**
  - ○ **The special income level for institutionalized persons**

    (*select one*):

    - ○ **300% of the SSI Federal Benefit Rate (FBR)**
    - ○ **A percentage of the FBR, which is less than 300%**

      Specify the percentage: [ ]
    - ○ **A dollar amount which is less than 300%.**

      Specify dollar amount: [ ]
  - ○ **A percentage of the Federal poverty level**

    Specify percentage: [ ]
  - ○ **Other standard included under the State Plan**

    Specify:

    [ ]
- ○ **The following dollar amount**

  Specify dollar amount: [ ] If this amount changes, this item will be revised.
- ◉ **The following formula is used to determine the needs allowance:**

  Specify:

  a) 100% of the Federal poverty level as a personal needs allowance, b) An allowance for the payment of guardianship fees of the individual under a Superior Court order of guardianship as allowed under the WAC, c) Earned income for the first $65 plus one-half of the remaining earned income, d) total needs

will not exceed SIL" for the maintenance needs of the waiver participants.

- **Other**

Specify:

ii. Allowance for the spouse only (*select one*):

- **Not Applicable**
- **The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:**

Specify:

Specify the amount of the allowance (*select one*):

- **SSI standard**
- **Optional State supplement standard**
- **Medically needy income standard**
- **The following dollar amount:**

Specify dollar amount: If this amount changes, this item will be revised.

- **The amount is determined using the following formula:**

Specify:

iii. Allowance for the family (*select one*):

- **Not Applicable (see instructions)**
- **AFDC need standard**
- **Medically needy income standard**
- **The following dollar amount:**

Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

- **The amount is determined using the following formula:**

Specify:

- **Other**

Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- **Not Applicable (see instructions)** *Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- **The State does not establish reasonable limits.**
- **The State establishes the following reasonable limits**

Specify:

The deduction for medical and remedial care expenses that were incurred as the result of imposition of a transfer of assets penalty is limited to zero.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 4)

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 4)

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan.. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant

(*select one*):

- **SSI standard**
- **Optional State supplement standard**
- **Medically needy income standard**

- **The special income level for institutionalized persons**
- **A percentage of the Federal poverty level**

  Specify percentage:
- **The following dollar amount:**

  Specify dollar amount: If this amount changes, this item will be revised
- **The following formula is used to determine the needs allowance:**

  Specify formula:

  a) Personal Needs Allowance - 100% of the Federal poverty level for a participant who does not reside with a community spouse or the Medically Needy income standard for a participant who does reside with a community spouse, b) An allowance for the payment of guardianship fees of the individual under a Superior Court order of guardianship as allowed under the WAC, c) Earned income for the first $65 plus one-half of the remaining earned income, d) total needs will not exceed SIL" for the maintenance needs of the waiver participants.
- **Other**

  Specify:

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

- **Allowance is the same**
- **Allowance is different.**

Explanation of difference:

Additional funds can be allocated to the community spouse who resides with the participant.

iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- **Not Applicable (see instructions)** *Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- **The State does not establish reasonable limits.**
- **The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B: Participant Access and Eligibility

B-6. Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level (s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for services:

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

ii. Frequency of services. The State requires (select one):

- (•) **The provision of waiver services at least monthly**
- ( ) **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

- ( ) **Directly by the Medicaid agency**
- ( ) **By the operating agency specified in Appendix A**
- ( ) **By an entity under contract with the Medicaid agency.**

Specify the entity:

- (•) **Other**

Specify:

The Medicaid agency performs the initial evaluation for level of care. Re-evaluations are performed by case management entity under contract with the Medicaid Agency.

c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

In addition to meeting the following minimum qualifications, staff must pass a background check prior to being hired and receive mandatory training prior to completing any evaluations.

Initial evaluations are performed by case managers who can be a Registered Nurse (licensed in the State) or a Social Worker. For Social Workers, minimum qualifications are as follows:

A Master's degree in social services, human services, behavioral sciences, or an allied field and two years of paid social service experience equivalent to a Social Worker 2.

OR

A Bachelor's degree in social services, human services, behavioral sciences, or an allied field, and three years of paid

social service experience performing functions equivalent to a Social Worker 2.

NOTE: A two year Master's degree in one of the above fields that included a practicum will be substituted for one year of paid social service experience.

NOTE: Employees must successfully complete the formal training course sponsored by their division within one year of their appointment.

NOTE: Equivalent social service experience would include the previous classes of Caseworker 3 or higher.

OR

For current employees the following experience qualifies for promotion to a Social Worker 3: A Bachelor's degree and three years of experience as a Caseworker 3, Social Worker 1A or B, Social Worker 2, Casework Supervisor Trainee, Casework Supervisor, Juvenile Rehabilitation Supervisor 1 or 2, or Juvenile Rehabilitation Counselor 2 in State service.

Job classification discriptions are available from the Medicaid agency.

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

The level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool is fully specified in WAC 388-106-0355 (eligiblity for nursing facility care services)and is summarized here:

Nursing Facility Level of Care (NFLOC)is based on the following factors:
1. The Comprehensive Assessment Reporting Eavaluation (CARE) tool is the assessment tool used to determine NFLOC. Functional criteria for NFLOC means one of the following applies:

a. Care is required to be provided by or under the supervision of a registered nurse or a licensed practical nurse on a daily basis;

b. The individual has an unmet or partially met need with at least three of the following activities of daily living. For each ADL a minimum level of assistance is required in self performance and/or support provided (self performance and support provided is defined below).

The minimum level of assistance required for each ADL is:
-Eating - Support provided is setup; or
-Toileting and bathing - Self performance is supervision; or
-Transfer, bed mobility, and ambulation - Self performance is supervision and support provided is setup; or
-Medication management - Self performance is assistance required; or
-If the need for assistance in any activities listed in this section did not occur because the individual was unable or no provider was available to assist, that need is counted for the purpose in determining functional eligibility; or

c. The individual has an unmet or partially met need with at least two of the following activities of daily living:
The minimum level of assistance required for each ADL is:
-Eating - Self performance is supervision and support provided one person physical assist; or
-Toileting - Self performance is extensive assistance and support provided is one person physical assist; or
-Bathing - Self performance is limited assistance and support provided is one person physical assist; or
-Transfer and Mobility - Self performance is extensive assistance and support provided is one person physical assist; or
-Bed Mobility – includes limited assistance in self performance and the need for turning and repositioning; and support provided is one person physical assist;
-Medication Management – Assistance required daily in self performance; or
-If the need for assistance in any activities listed in this section did not occur because the individual was unable or no provider was available to assist, that need is counted for the purpose in determining functional eligibility; or

(d) The individual has a cognitive impairment and requires supervision due to one or more of the following: Disorientation, memory impairment, impaired decision making, or wandering and have an unmet or partially met need

with at least one or more of the following:
The minimum level of assistance required for each ADL is:
-Eating - Self performance is supervision and support provided one person physical assist; or
-Toileting - Self performance is extensive assistance and support provided is one person physical assist; or
-Bathing - Self performance is limited assistance and support provided is one person physical assist; or
-Transfer and Mobility - Self performance is extensive assistance and support provided is one person physical assist; or
-Bed Mobility – includes limited assistance in self performance and the need for turning and repositioning; and support provided is one person physical assist;
-Medication Management – Assistance required daily in self performance; or
-If the need for assistance in any activities listed in this section did not occur because the individual was unable or no provider was available to assist, that need is counted for the purpose in determining functional eligibility.

"Self performance for ADLs" means what the individual actually did in the last seven days before the assessment, not what he/she might be capable of doing. Coding is based on the level of performance that occurred three or more times in the seven-day period. Self-performance definitions and assessments are consistant with that used under the Minimum Data Set (MDS). This provides a common set of clinical data across all long term care settings.Self performance level is scored as:

(a) Independent if the individual received no help or oversight, or if the individual needed help or oversight only once or twice;

(b) Supervision if the individual received oversight (monitoring or standby), encouragement, or cueing three or more times;

(c) Limited assistance if the individual was highly involved in the activity and given physical help in guided maneuvering of limbs or other nonweight bearing assistance on three or more occasions. For bathing, limited assistance means physical help is limited to transfer only;

(d) Extensive assistance if the individual performed part of the activity, but on three or more occasions, the individual needed weight bearing support or the individual received full performance of the activity during part, but not all, of the activity. For bathing, extensive assistance means the individual needed physical help with part of the activity (other than transfer);

(e) Total dependence if the individual received full caregiver performance of the activity and all subtasks during the entire seven-day period from others. Total dependence means complete nonparticipation by the individual in all aspects of the ADL; or

(f) Activity did not occur if the individual or others did not perform an ADL over the last seven days before the individual’s assessment. The activity may not have occurred because:

(i) The individual was not able (e.g., walking, if paralyzed);

(ii) No provider was available to assist; or

(iii) The individual declined assistance with the task.

"Support provided" means the highest level of support provided to the individual by others in the last seven days before the assessment, even if that level of support occurred only once.

(a) No set-up or physical help provided by others;

(b) Set-up help only provided, which is the type of help characterized by providing the individual with articles, devices, or preparation necessary for greater self performance of the activity. (For example, set-up help includes but is not limited to giving or holding out an item or cutting food);

(c) One-person physical assist provided;

(d) Two- or more person physical assist provided; or

(e) Activity did not occur during entire seven-day period.

Washington uses an automated assessment system called the Comprehensive Assessment Reporting Evaluation (CARE) tool to evaluate and reevaluate level of care criteria required by the waiver. The CARE tool is available to CMS upon request through the Medicaid agency.
The functions, elements and scoring mechanisms of CARE are spelled out in the Washington State Administrative Code (WAC).

e. Level of Care Instrument(s). Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

- (●) **The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**
- ( ) **A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

f. Process for Level of Care Evaluation/Reevaluation: Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

Case managers complete Level of Care evaluations using the automated assessment tool (CARE). CARE is used for both initial evaluations and re-evaluations. The re-evaluation process does not differ from the initial evaluation process. Evaluations are completed initially, at annual review, and when a significant change occurs. Case managers complete annual and significant change reviews. The recipient's assigned case manager is responsible for completing re-evaluations.

Information about the person's support needs is obtained via a face to face interview. Evaluators also obtain and verify information by collateral contacts with formal and informal supports including physicians, home health agencies, caregivers and family.

g. Reevaluation Schedule. Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

- ( ) **Every three months**
- ( ) **Every six months**
- ( ) **Every twelve months**
- (●) **Other schedule**
  Specify the other schedule:

Re-evaluations must be completed every twelve months and whenever there is a significant change in the client's condition.

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations *(select one)*:

- (●) **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ( ) **The qualifications are different.**
  Specify the qualifications:

i. Procedures to Ensure Timely Reevaluations. Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care *(specify):*

CARE generates an assessment timeliness report that notifies case managers of the need to conduct reevaluations. Case mnagers use these reports to assure the timeliness of annual reviews. In addition to timeliness reports, an automated "tickler" notifies the case manager 40 days in advance of the upcoming reassessment date.

Case management supervisors have a required schedule of record reviews for individual case managers and are responsible for evaluating staff on assessment timeliness. In addition, supervisors use reports produced by CARE to track timeliness of assessments.

Quality monitoring of records includes monitoring for timeliness.

j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Electronically retrievable documentation of all evaluations and reevaluations is maintained for a minimum of three years at the state level. Written documentation of all evaluation and reevaluations are maintained for a minimum of three years at the local office.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Level of Care Assurance/Sub-assurances

i. Sub-Assurances:

a. ***Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percent of all applicants that have applied for a LOC determination and have a completed assessment. (Excludes individuals that withdrew their request, died,or are not financially eligible) N=All waiver applicants who have a completed LOC assessment D=All waiver applicants

Data Source (Select one):
Other
If 'Other' is selected, specify:
Administrative Data

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**

☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State

to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percent of waiver participants who received a redetermination of LOC within annual time frame. N=All waiver participants who received a timely annual redetermination of LOC D=All waiver participants reviewed where a redetermination was due

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: 18 months	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

	☐ **Continuously and Ongoing**
	☑ **Other** Specify: 18 months

Performance Measure:
Percent of significant changes that occured when warranted by changes in the waiver participants needs N: Number of records reviewed where a significant change assessemnt was completed when indicated D: Number of records reviewed

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: 18 months	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**

☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: 18 months

c. ***Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Overall proficiency for QA LOC elements N=Number of LOC elements reviewed that meet proficiency standard D= Number of LOC elements reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
QA monitoring database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
The CARE assessment as specified in the waiver is the only assessment tool used to determine LOC. To determine LOC, case managers use CARE which is a standardized assessment tool based on the MDS. QA staff and supervisors/managers monitor for appropriate application of the CARE instrument and processes to meet sub-assurance c: (The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care).

Practices to ensure inter-rater reliability include:
• Three day CARE training for all new staff
• QA staff periodically complete LOC determinations to evaluate inter rater reliability
• QA staff provide intermittent training and consultation
• Supervisors monitor 50% of all new LOC determinations in the first 6 months.

Social service supervisors/managers annually monitor four records per experienced worker to ensure LOC accuracy and that a LOC is determined annually or at significant change. For new staff, a minimum of 50% of LOCs are reviewed during the first six months of employment. Errors in assessment that can lead to an inaccurate LOC determination are corrected. ADSA QA staff monitor LOC using a statistically valid sample of records on an 18 month review cycle.

Monitoring data provide evidence of use of the CARE application. LOC determinations that are not correctly determined are corrected and correction is verified at second review. Training to address use of the CARE

application is developed based on the data.

CARE enforces rules of eligibility. An algorithm in CARE determines LOC based on information entered in to the assessment by the participant and case manager. A LOC determination is completed on all applicants for whom there is reasonable indication that services may be needed in the future. If the participant is not New Freedom eligible, the option is not available for the participant/case manager to select/choose and will not print on the service summary (plan of care).
-An Intake is completed at the state agency (HCS) within two working days of receiving the request/referral for services – referrals are entered within one working day for applicants discharging from the hospital.
- The case is assigned to a social worker (the primary case manager) within one working day of the intake date

- A face-to-face contact is made within two working days of receipt of the referral for applicants coming home from the hospital.
- The assessment process must be completed and services authorized (if eligible) within 30 days of the date of assignment.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
- CARE, QA and payment reports are reviewed and corrective action taken on an on-going basis by supervisors. Case managers are required to take action with specified time frames to address all inappropriate LOC determinations identified during the supervisory and QA monitoring. CARE management reports include data elements such as: intake date, first assigned date, primary case manager, date assessment created, date moved from pending to current (make payment), setting and transfer dates.

- Quality assurance proficiency and follow-up reports (Proficiency Report for Follow-Up Review outlines LOC decisions and corrective actions taken) document prompt assessment and eligibility determinations, accuracy, and corrective action.

Corrective actions plans are required for areas where required proficiency levels are not achieved or if improvement is not evident based upon previous corrective actions. Corrective action plans are evaluated by ADSA prior to ADSA's approval to ensure that plan will effectively address areas that need improvement. Training elements of corrective action plans are coordinated through ADSA and ADSA staff is made available to provide training and technical support. An update at six months is required to report on progress toward implementing corrective actions.

Identified trends are forwarded to the ADSA program managers and Training, Development and Communication unit for training development.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

- (●) **No**
- ( ) **Yes**

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. *As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

i. informed of any feasible alternatives under the waiver; and
ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

After performing a comprehensive assessment of the participant, the social worker/case manager responsible for the evaluation will offer waiver services to a financially eligible individual when: The applicant is found eligible for nursing facility level of care; and a feasible community-based plan of care which adequately meets the health and personal needs of the applicant can be developed. The participant's choice whether to accept the offer of waiver services or be admitted to a nursing facility will prevail.

The DSHS form 14-225, "Acknowledgement of Services", is used to document the applicant/recipient's freedom to choose between institutional and home and community-based services . The DSHS form 14-225 is explained to the individual and a signature is obtained stating that the individual understands they have a choice in the type of services received, where the service is provided as well as the right to a fair hearing. The individual signs this form to designate the service choice.

Fair hearing information is referenced on the DSHS form 14-225, "Acknowledgement of Services" form. Rights to a fair hearing are explained to all individuals during the Medicaid application process and again during the assessment process.

The individual receives a signed copy of the DSHS 14-225 and a copy of the form is maintained in the applicant/recipients' case records, together with the applicant/recipient' evaluations and reevaluations.

b. Maintenance of Forms. Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

Copies of forms are maintained for a minimum of 3 years in the client record at the local office where case management for the client occurs.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

Equal access will be provided to people who are Limited English Proficient seeking waiver services by providing contracted interpreter services at no cost to the participant or bilingual staff. Program materials will be translated in participant's primary language. Outreach materials explaining the program will be translated into eight different languages.

The Department of Social and Health Services and its contractors are required by statute, administrative code and department policy to deliver services that recognize individual and cultural differences. All clients must be given equal access to services, information, and programs whether the department or contracted vendors deliver services. The following are summaries of requirements:

1.Interpreters are used when interpreter services are requested by the client; necessary to determine a client's eligibility for services; necessary for the client to access services.

2.LEP and Sensory Impaired (SI) clients are informed of their right to request an interpreter or auxiliary aide and are offered interpreter services or auxiliary aids at no cost to them and without significant delay. Children under age 18 are not allowed to serve as interpreters. LEP Interpreters and Translators for spoken language must be certified and/or qualified by DSHS and comply with the DSHS code of professional conduct.

3.To assure access and quality, DSHS maintains a statewide translation contract, American Sign Language contract and Interpreter Brokerage contract for Spoken Languages.

4. If the listed contractors cannot meet the need, or there is an emergency, which requires the immediate attention, staff can access the Language Line.

5. Procedures are in place to obtain translation of official publications, forms and records as well as client specific requests for translations.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. Waiver Services Summary. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Service Type	Service
Statutory Service	**Personal Assistance Services (PAS)**
Other Service	**Environmental and Vehicle Modifications**
Other Service	**Individual Directed Goods, Services and Supports**
Other Service	**Training and Educational Supports**
Other Service	**Treatment and Health Maintenance**

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Personal Care

Alternate Service Title (if any):

Personal Assistance Services (PAS)

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Supports involving the labor of another person to help waiver participants carry out everyday activities they are unable to perform independently. Services may be provided in the person's home or in the community.

The following are included in PAS:
Direct personal care services defined as assistance with activities of daily living (ambulation, bathing, body care, dressing, eating, personal hygiene, positioning, self-medication, toileting, and transfer. Personal care under the waiver differs in scope from personal care services in the State plan in that it may only be provided to waiver participants who are not eligible for State plan personal care or whose needs exceed what can be provided solely under State plan personal care.

Delegated health related tasks as defined in Washington State Nurse Delegation rule. Providers of direct personal care services may be asked to perform certain delegated tasks.

Homemaking, or assistance with instrumental activities of daily living (essential shopping, housework, meal preparation).

Other task or assistance with activities that support independent functioning, and are necessary due to the functional disability.

Personal assistance with transportation to enable waiver participants to gain access to waiver and other community services, activities and resources, as specified by the PCSP. This service is offered in addition to medical transportation required under 42 CFR §431.53 and transportation services under the State plan, defined at 42 CFR §440.170(a) (if applicable), and does not replace them. Transportation services under the waiver are offered in accordance with the participant's PCSP.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**
- [ ] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual Providers
Agency	Home Care Agency/ Home Health Agency
Individual	Individual Entrepreneurs

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Personal Assistance Services (PAS)

Provider Category:
Individual
Provider Type:
Individual Providers
Provider Qualifications
License *(specify):*

Certificate *(specify):*
Individual providers must contract with the Department before providing personal care services. The case manager is responsible for completing all contracting steps. Prior to contracting the case manager must verify that the individual provider:
a. is authorized to work in the United States
b. Has passed a background check
c. is age 18 or older

Individual providers must complete the following training requiremens:
1. Caregiver orientation within 14 days of hire
2. Revised Fundamentals of Caregiving must be completed within 120 days of employment.
Note: An IP may take the Modified Fundamentals of Caregiving Self-Study course in lieu of the full Fundamentals course, if the IP documents successful completion of training as an RN, LPN, nursing assistant certified, PT, OT, or a Medicare certified home care aide.
3. Continuing education of 10 hours each calendar year
4. Required training for an IP who will be performing a nurse delegated task.
Other Standard *(specify):*
Individuals who provide transportation must have a valid driver license and meet state requirements for insurance coverage.
Verification of Provider Qualifications
Entity Responsible for Verification:
Fiscal Management Agency
Frequency of Verification:
Initially and every two years for background checks. If there is reasonable cause to believe that the provider has been arrested or convicted of a disqualifying crime within the two year cycle, the FMS must complete a new background check.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Personal Assistance Services (PAS)

Provider Category:
Agency
Provider Type:
Home Care Agency/ Home Health Agency
Provider Qualifications
License *(specify):*
licensed under chapter 70.127 RCW or Home Health Agency License under Chapter 70.127 RCW
Certificate *(specify):*

Other Standard *(specify):*
In order to be employed by a home care agency to provide personal assistance services, a person must complete the department's criminal conviction background inquiry application, which is submitted by the agency to the department. This includes an FBI fingerprint-based background check if the home care agency provider has lived in the state of Washington less than three years. The employee must also meet the training requirements outlined in statute.

2 hours of Orientation
28 hours of Revised Fundamentals of Caregiving (RFOC)
10 hours Continuing Education annually beginning the year following RFOC

All professional staff must have appropriate licensure and certification as outlined in state statute:

Verification of Provider Qualifications

Entity Responsible for Verification:
Fiscal Management Agency

Frequency of Verification:
Upon executing/renewing contract
License renewal every two years
Contract compliance monitoring every two years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Personal Assistance Services (PAS)

Provider Category:
Individual

Provider Type:
Individual Entrepreneurs

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Individual entrepreneurs are subject to any licensing or local codes relevant to task they are going to perform. Additional requirements, specific to the service provided, are clearly defined in the Participant Spending Plan. For example, the knowledge of sign language or the completion of training specific to the participant may be required.

Verification of Provider Qualifications

Entity Responsible for Verification:
Fiscal Management Agency

Frequency of Verification:
Initially and every two years for background checks. If there is reasonable cause to believe that the provider has been arrested or convicted of a disqualifying crime within the two year cycle, the FMS must complete a new background check.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Environmental and Vehicle Modifications

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (•) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
These modifications and supports are comprised of environmental or vehicle modifications to a participant's residence or vehicle necessary to accommodate the participant's disability and promote functional independence, health, safety and welfare. Some examples of services are the installation of ramps and grab-bars, widening of doorways, minor household repairs, modification of bathroom facilities, specialized equipment, installation of specialized electric and plumbing systems which are necessary to accommodate needed medical equipment and specialized accessibility and fire safety adaptations.

Examples of vehicle modifications include adaptive vehicle controls related to steering, braking, shifting, signaling and acceleration, lift devices, seat adaptations, hand rails, and door widening.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Alterations to the home which are of general utility and not of direct medical or remedial benefit to the waiver participant are excluded. Alterations that add to the total square footage of the home are excluded. Services in this waiver will not duplicate or replace other state plan services. Vehicle modifications are limited to vehicles owned by the participant or the participant's family, when residing with the participant, and demonstrate cost effectiveness when compared to available alternative transportation.

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**
- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual Entrepreneurs and Businesses

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental and Vehicle Modifications

Provider Category:
Individual
Provider Type:
Individual Entrepreneurs and Businesses
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
All providers must possess any valid license or certification or registration required by State or local law. All services shall be provided in accordance with applicable State or local building codes and meet specifications, if applicable, for modification as set by the American National Standards Institute (ANSI). Providers shall possess a current license to do business issued in accordance with the laws of the local jurisdiction and shall demonstrate knowledge in meeting applicable standards of installation, repair and maintenance and where applicable shall also be authorized by the manufacturer to install, repair and maintain such modifications/adaptations. Home modifications must meet life/safety and building codes and be inspected by the appropriate authority when required.

Verification of Provider Qualifications

Entity Responsible for Verification:
FMS

Frequency of Verification:
Initially upon contracting and at each subsequent utilization of the provider.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Individual Directed Goods, Services and Supports

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (•) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Goods, services, and supports are services, equipment or supplies not otherwise provided through this waiver or through the Medicaid State Plan that address an identified need in the comprehensive assessment and Person Centered Spending Plan (PCSP). Goods, services, equipment, and other supports that allow the waiver participant to function more independently, or increase safety and welfare, or allow the person to perceive, control or communicate with their environment. Some examples of services are environmental supports (e.g., snow removal, heavy cleaning); assistive technology; supplies and equipment; adaptive clothing; special diets; home delivered meals; trained service animals including purchase, upkeep and veterinarian services; repairs and maintenance of equipment; equipment and services that reduce the need for on-site supervision in an emergency; transportation not provided by personal assistant. As a Medicaid funded service, this definition will not cover experimental goods and services.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Services in this waiver category will not duplicate or replace other state plan services.
Veterinary care is available only to service animals.
Meals provided as part of these services shall not constitute a “full nutritional regimen” (3 meals per day).

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**

☐ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual Entrepreneurs
Individual	Transportation
Individual	Veterinarians
Individual	Food Service Vendor

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Individual Directed Goods, Services and Supports

Provider Category:
Individual

Provider Type:
Individual Entrepreneurs

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Individual entrepreneurs are subject to any licensing,(e.g., approved contractor trade license, teaching certificate) or local codes relevant to task they are going to perform and additional requirements clearly defined in the individualized person centered spending plan(e.g. Peer Support for addressing disability related issues, person centered planning, individual budgeting, employing IP's)

Providers must have a current license or certificate if required by state law per RCW 18. A provider must meet all professional standards and/or training requirements per state statutes.

For providers that do not require professional licensing the participant will define qualifications in the spending plan. The PCSP may identify additional qualifications that the person must meet to provide the service.

Verification of Provider Qualifications

Entity Responsible for Verification:
Financial Management Agency

Frequency of Verification:
Initially upon contracting and at each subsequent utilization of the provider.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Individual Directed Goods, Services and Supports

Provider Category:
Individual
Provider Type:
Transportation
Provider Qualifications
License *(specify):*
Certificate *(specify):*
Other Standard *(specify):*
For transportation, standards are the same for common carrier transportation of taxi cab, bus, other commercial carrier, or private automobile. Individuals who provide transportation must have a valid driver license and meet state requirements for insurance coverage.
Verification of Provider Qualifications
Entity Responsible for Verification:
Financial management Agency
Frequency of Verification:
Initial contract and annually thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Individual Directed Goods, Services and Supports

Provider Category:
Individual
Provider Type:
Veterinarians
Provider Qualifications
License *(specify):*
Licensed under State Statute.
Certificate *(specify):*
Other Standard *(specify):*
Verification of Provider Qualifications
Entity Responsible for Verification:
Financial management Agency
Frequency of Verification:
Initially upon contracting and at each subsequent utilization of the provider.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Individual Directed Goods, Services and Supports

Provider Category:
Individual

Provider Type:
Food Service Vendor
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Meet all state board of health standards for food service under RCW 43.20.050 to promote and protect the health, safety, and well-being of the public and prevent the spread of disease through food. Meals may be provided by restaurants, cafeterias or caterers who comply with Washington State Department of Health and local board of health regulations for food service establishments.
Verification of Provider Qualifications
Entity Responsible for Verification:
Financial management Agency
Frequency of Verification:
Initially upon contracting and at each subsequent utilization of the provider.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Training and Educational Supports

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- **Service is included in approved waiver. There is no change in service specifications.**
- **Service is included in approved waiver. The service specifications have been modified.**
- **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Training and educational supports beyond the scope of state plan services that are necessary to promote the participants health and ability to live and participate in the community. This service category includes training or education on participant health issues or personal skill development that improves the participants own ability to accomplish everyday activities and maintain, slows decline, or improves functioning and adaptive skills, Includes training/education to paid or unpaid caregivers related to the needs of the waiver participant.
Training and Educational supports will address an identified need in the Participant Centered Spending Plan.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Waiver services in this category are not within the scope of or applicable to the Individuals with Disabilities Education Act (IDEA).

Service Delivery Method *(check each that applies)*:

- **Participant-directed as specified in Appendix E**
- **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community Colleges
Individual	Individual Entrepeneurs
Individual	Health Care Providers

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Training and Educational Supports

Provider Category:
Agency
Provider Type:
Community Colleges
Provider Qualifications
License *(specify):*
Community Colleges are established, described and regulated in Chapter 28B.50.020 RCW.
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Finanacial Management Service
Frequency of Verification:
Initially upon contracting and at each subsequent utilization of the provider.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Training and Educational Supports

Provider Category:
Individual
Provider Type:
Individual Entrepeneurs
Provider Qualifications
License *(specify):*
Individual entrepreneurs are subject to any licensing relevant to the task they are going to perform.
Certificate *(specify):*

Other Standard *(specify):*
Additional requirements are clearly defined in Person Centered Spending Plan. A provider must meet all professional standards and /or training requirements which may be required by state statute.

Verification of Provider Qualifications

Entity Responsible for Verification:
Financial management Service

Frequency of Verification:
Initially upon contracting and at each subsequent utilization of the provider.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Training and Educational Supports

Provider Category:
Individual

Provider Type:
Health Care Providers

Provider Qualifications

License *(specify):*
Providers must meet all stautory professional standards and licensing requirements and have a current license to practice in the state.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
Financial Management Agency

Frequency of Verification:
Initially upon contracting and at each subsequent utilization of the provider.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Treatment and Health Maintenance

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (•) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Treatment and health maintenance supports, beyond the scope of state plan services, necessary to promote the

participant's health and ability to live and participate in the community. Services are provided for the purpose of preventing further deterioration, improving or maintaining current level of functioning. Supports and services categorized here include those typically performed or provided by people with specialized skill, certification or licenses. Some examples of services and supports that can be covered are specialized health care, extended therapeutic treatment, dental, vision, audiology, culturally appropriate health services(culturally and linguistically sensitive health care in the areas of primary care, prevention & wellness, e.g. acupuncture, naturopathic medicine); therapeutic massage complementary to physical therapy or provided as a less intrusive alternative, and physical therapy. Services provided under the waiver shall be in addition to any available under the approved State plan when limits are exhausted, beyond the scope of state plan services and are included in participants consumer directed plan to augment state plan services. Service providers must possess the appropriate professional licensing per Title 18 RCW.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Care Agencies
Individual	Licensed health practitioner
Agency	Home Health Agency
Agency	Adult Day Care Centers
Individual	Individual Entrepreneur

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Treatment and Health Maintenance

Provider Category:
Agency
Provider Type:
Home Care Agencies
Provider Qualifications

License *(specify)*:
licensed under chapter 70.127 RCW
Certificate *(specify)*:

Other Standard *(specify)*:
In order to be employed by a home care agency to provide personal assistance services, a person must complete the department's criminal conviction background inquiry application, which is submitted by the agency to the department. This includes an FBI fingerprint-based background check if the home care agency provider has lived in the state of Washington less than three years. The employee must also meet the training requirements outlined in statute.

All professional staff must have appropriate licensure and certification as outlined in state staute.

Verification of Provider Qualifications

Entity Responsible for Verification:
Financial management Services

Frequency of Verification:
Upon executing/renewing contract every two years
License renewal every two years
Contract compliance monitoring every two years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Treatment and Health Maintenance

Provider Category:
Individual

Provider Type:
Licensed health practitioner

Provider Qualifications

License *(specify):*
Providers must meet all stautory professional standards and licensing requirements and have a current license to practice in the state.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
Financial management Services

Frequency of Verification:
Initially upon contracting and at each subsequent utilization of the provider.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Treatment and Health Maintenance

Provider Category:
Agency

Provider Type:
Home Health Agency

Provider Qualifications

License *(specify):*
licensed under chapter 70.127 RCW

Certificate *(specify):*

Other Standard *(specify):*
All professional staff employed by the agency to provide waiver services must meet any applicable stautory licensing and certification requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:
Financial Management Services
Frequency of Verification:
Upon executing/renewing contract every two years
License renewal every two years
Contract compliance monitoring every two years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Treatment and Health Maintenance

Provider Category:
Agency
Provider Type:
Adult Day Care Centers
Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
(1) Minimum staffing requirements for adult day care centers include an administrator/program director, activity coordinator, a consulting registered nurse, and a consulting social worker.

(2) The administrator/program director must have a master's degree and one year of supervisory experience in health or social services (full-time equivalent); or a bachelor's degree in health, social services or a related field, with two years of supervisory experience (full-time equivalent) in a social or health service setting; or a high school diploma or equivalent and four years of experience in a health or social services field, of which two years must be in a supervisory position, and have expertise with the populations served at the center.

Verification of Provider Qualifications

Entity Responsible for Verification:
Financial management Services
Frequency of Verification:
Upon initial contracting
Annual review per WAC 388-71-0724
Contract compliance monitoring every two years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Treatment and Health Maintenance

Provider Category:
Individual
Provider Type:
Individual Entrepreneur
Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Individual entrepreneurs are subject to any licensing or local codes relevant to the task they are going to perform and additional requirements clearly defined in plan of service/spending plan.

For providers that do not require professional licensing the participant will define qualifications in the PCSP. The PCSP may identify additional qualifications that the person must meet to provide the service.

Verification of Provider Qualifications

Entity Responsible for Verification:
Financial management Agency

Frequency of Verification:
Initially upon contracting and at each subsequent utilization of the provider.

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

- ☐ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- ☐ **As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- ☐ **As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- ☑ **As an administrative activity.** *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Case management is provided by State case managers and the contracted case management entity as an administrative activity.

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

- ○ **No. Criminal history and/or background investigations are not required.**
- ◉ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be

conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

Per RCW 43.20A.710: Background checks are required for individual providers and employees of home care agencies and other individuals paid to provide in-home care involving unsupervised access to waiver participants. The investigation includes examination of state data, and if the provider has resided in the state for less than 3 years, includes national data. Individual providers must have a satisfactory background check before a contract is finalized. WAC 388-06 describes state policy. Background checks are conducted at no expense to the waiver participant. The entity originally requesting the background check receives a letter outlining the findings of the background check from the Background Check Central Unit. This letter is used to determine whether a potential provider is cleared for contracting. Contracts cannot be executed and providers cannot be paid without evidence of complete background check which includes abuse registry screening.

b. Abuse Registry Screening. Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (select one):

- ○ **No. The State does not conduct abuse registry screening.**
- ◉ **Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Under state authority, Aging and Disability Services Administration/Home and Community Services Division, Adult Protective Services (APS) receives reports and conducts investigations of abuse (physical, mental, sexual, and exploitation of person), abandonment, neglect, self neglect, and financial exploitation. Findings, (final investigation outcome results in substantiation of abuse, neglect, exploitation) are forwarded to the DSHS Background Check Central Unit (BCCU) by the statewide APS program manager. The BCCU enters the information into their database used to screen all names submitted for a background check. The Department of Social and Health Services (DSHS) maintains a registry of the identity of a person or entity with a final finding of abandonment, abuse, financial exploitation or neglect.

Prior to providing contracted waivers services, the DSHS requires screening of individuals through the BCCU which includes the abuse registry findings and available information from the Washington State Patrol (WSP), the Department of Corrections (DOC), the Department of Social and Health Services (DSHS), the Department of Health (DOH), and depending on program requirements, from other states. This includes an FBI fingerprint-based background check if the provider has lived in the state of Washington less than three years.

This requirement applies to any current employee or applicant seeking or being considered for any position with the department who will or may have unsupervised access to children, vulnerable adults, or individuals with mental illness or developmental disabilities. This includes, but is not limited to, positions conducting comprehensive assessments, financial eligibility determinations, licensing and certification activities, investigations, surveys, or case management; or for state positions otherwise required by federal law to meet employment standards; Individual providers who are paid by the state and providers who are paid by home care agencies to provide in-home services involving unsupervised access to persons with physical, mental, or developmental disabilities or mental illness, or to vulnerable adults as defined in chapter 74.34 Revised Code of Washington (RCW), including but not limited to services provided under chapter 74.39 or 74.39A RCW.

The entity originally requesting the background check receives a letter outlining the findings of the background check from the Background Check Central Unit. This letter is used to determine whether a potential provider is cleared for contracting. Contracts cannot be executed and providers cannot be paid without evidence of complete background check which includes abuse registry screening.

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

- **No. Home and community-based services under this waiver are not provided in facilities subject to §1616 (e) of the Act.**
- **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

- **No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- **Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

- **The State does not make payment to relatives/legal guardians for furnishing waiver services.**
- **The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

- **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

A participant may choose a representative to provide services except a spouse/married or legally separated. (New Freedom is not applicable to minor children) The representative must meet the provider qualifications, including required fundamentals of care giving training that any other provider must meet in order to be a contracted and paid provider. Accountability systems regarding receipt and payment for waiver services provided are also applicable to providers who are representatives As with providers who are not representatives of the participant, per WAC 388-71-0551, the department or contracted AAA, Consultant Support Service or FMS may take action to terminate the provider's contract if the representative's inadequate performance or inability to deliver quality care is jeopardizing the participant's health, safety, or wellbeing. The department or AAA may summarily suspend the contract pending a hearing based on a reasonable, good faith belief that the client's health, safety, or well-being is in imminent jeopardy. Examples of circumstances indicating jeopardy to the client could include, without limitation:

(1) Domestic violence or abuse, neglect, abandonment, or exploitation of a minor or vulnerable adult;

(2) Using or being under the influence of alcohol or illegal drugs during working hours;

(3) Other behavior directed toward the client or other persons involved in the client's life that places the client at risk of harm;

(4) A report from the client's health care provider that the client's health is negatively affected by inadequate care;

(5) A complaint from the client or client's representative that the client is not receiving adequate care;

(6) The absence of essential interventions identified in the service plan, such as medications or medical supplies

○ **Other policy.**

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

Individual providers of personal care who meet published qualifications can enroll any time. Participants who use individual providers of personal care services can choose their provider. If a participant chooses a provider who is not enrolled, the FMS assists the proposed provider with enrollment by providing background checks, training and contracting. Any willing and qualified provider has the opportunity to enroll any time. The state maintains an open registry of qualified providers. Qualifications are published in WAC and are available to the public via web access and by hard copy upon request.

Participants who use individual providers of personal care services choose their provider. If a participant chooses a provider who is not enrolled, the FMS assists the proposed provider with enrollment by providing background checks, training and contracting. Any willing and qualified provider has the opportunity to enroll any time. The state maintains an open registry of qualified providers. Qualifications are published in WAC and are available to the public via web access and by hard copy upon request.

For all other waiver services, the FMS establishes qualifications and offers the opportunity for any willing provider to demonstrate qualifications and enroll. The FMS continuously seeks to build its pool of waiver service providers in order to offer a wide array of choice to enrollees by actively recruiting and enrolling qualified providers. Waiver service provider enrollment is open and continuous by FMS policy and State requirement.

The FMS Purchasing Specialist assists interested providers by providing written and verbal information regarding qualification requirements, enrollment procedures and other information about the process as needed by the applicant.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the

State's methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

i. Sub-Assurances:

a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
The percentage of waiver service providers that meet licensing and/or certification requirements at the time of initial Medicaid contracting. Numerator: All waiver service providers that meet licensing and/or certification requirements at the time of initial Medicaid contracting. Denominator: All contracted waiver service providers that require licensure and/or certification

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify:	

	24 months	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: 24 months

Performance Measure:
The percentage of waiver service providers that continue to meet meet licensing and/or certification requirements at the time of Medicaid contract renewal. N: All waiver service providers that continue to meet licensing and/or certification requirements at the time of Medicaid contract renewal. D: All contracted waiver service providers that require licensure and/or certification

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☑ **Other** Specify: 24 months	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: 24 months

Performance Measure:
The percent of Home Care Agency providers that meet licensing requirements at time of initial Medicaid contracting N=Home Care Agency providers that meet licensing requirements at initial contracting D=All Home Care Agency providers contracted

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe

AAA		Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: AAA	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
The percent of Home Care Agency providers that continue to meet licensing requirements at time of Medicaid contract renewal N=Home Care Agency providers that continue to meet licensing requirements at time of contract renewal D=All Home Care Agency providers contracted

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample**

		Confidence Interval =
☑ **Other** Specify: AAA	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: AAA	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
The percent of individual providers that meet waiver requirements N= # of contracted individual providers that meet waiver requirements D=# of contracted individual providers

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: 24 months	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**

	☑ **Other** Specify: 24 months

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
The percentage of individual providers providing services that meet training requirements Numerator: Number of Individual Providers providing servcies that meet training requirements Denominator: Number of Individual Providers providing services

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: 24 months	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: 24 months

Performance Measure:
Percent of Home Care Agency providers that meet training requirements
Numerator: Number of Home Care Agency providers reviewed that meet training requirements Denominator: Number of Home Care Agency providers reviewed

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: AAA	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other**	

	Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: AAA	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percent of RNs providing Nurse Delegation that have met training requirements Numerator: Number of RNs reviewed that provide nurse delegation and have met training requirements Denominaotr: Number of RNs reviewed that provide nurse delegation

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:

☐ **Continuously and Ongoing**	☐ **Other** Specify:
☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

-Nurse delegators are contracted for two years after verification that all requirements are met. To ensure that all contracts are current and up to date, all contracts are renewed at the same time on a two year cycle.

- Agency providers are monitored by the Area Agency on Aging (AAA). Reports are provided to the Medicaid Agency (ADSA) annually. Comprehensive contract monitoring is conducted every other year. On alternate years, a focus monitoring is conducted. The Medicaid Agency reviews reports on an ongoing basis that are provided by the AAA to verify that monitoring and remediation of providers are occurring. The New Freedom Financial Management Service monitors for contract compliance with licensing and insurance and may contract only with HCAs that are monitored by the AAA.

- Nursing Assistant Certified (NAC) and Nursing Assistant Registered (NAR) must complete required training to be able to perform delegated tasks. The State (Department of Health) maintains a registry system which verifies contract status.

- Other waiver service contracts are monitored by the Financial Management Service which is verified by the State.

- Individual providers must meet all requirements prior to contracting. Contracts are maintained and monitored by the FMS.

- Waiver participants who employe an Individual Provider to provide their personal care, hire, train and supervise qualified providers, are free to terminate the provider's employment and select new providers. Individual and agency providers must complete Fundamentals of Care Giving within 14 days of beginning employment. Revised Fundamentals of Caregiving must be completed within 120 days of employment. Note: An IP may take the Modified Fundamentals of Caregiver Self-Study course in lieu of the

full Fundamentals course if the IP documents successful completion as an RN, LPN, or NAC, PT, OT, or a Medicare certified home health aide. Continuing education of 10 hours must be completed each calendar year following the Fundamental training. Individual provider or home care agency worker who will be performing a nurse delegated task must meet the required training outlined in WAC 388-71-05805 through WAC 388-71-05830. Payment is terminated if the IP/agency worker does not complete the required training prior to providing a delegated task.
- The QA team monitors a statistically valid sample of provider files/qualifications. Monitoring includes verification that:
o Background checks are completed and passed
o Provider contract is completed and valid
o Required training was completed within the timeframes indicated
- Providers subject to licensing or certification are valid at the time of contract renewal and per individual licensing or certification schedule.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The State monitors the FMS to verify that the FMS is executing provider contracts correctly. Upon completion of each provider file review, the FMS is expected to make necessary corrections. Corrections are verified by either the QA team or the FMS supervisor. The QA team verifies that required corrections have been made at the individual level within 40 days of the preliminary review and documents the verification in the QA monitoring database. Items related to health and safety and payment, require either immediate action or within three working days depending on the situation. Supervisors verify that corrections have been made at the individual level prior to completing the review and document this activity in the QA database.

The FMS terminates contracts for providers if qualifications are not met.

The FMS provides technical assistance if standards are not met for other provider contracts they manage. Failure to make required changes can lead to contract termination.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing

identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

- (●) **Not applicable** - The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
- ( ) **Applicable** - The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

- [ ] **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
  Furnish the information specified above.

- [ ] **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
  Furnish the information specified above.

- [ ] **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
  Furnish the information specified above.

- [ ] **Other Type of Limit.** The State employs another type of limit.
  Describe the limit and furnish the information specified above.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:
Person Centered Spending Plan

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

- ☐ **Registered nurse, licensed to practice in the State**
- ☐ **Licensed practical or vocational nurse, acting within the scope of practice under State law**
- ☐ **Licensed physician (M.D. or D.O)**
- ☐ **Case Manager** (qualifications specified in Appendix C-1/C-3)
- ☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).

  Specify qualifications:

- ☐ **Social Worker.**

  Specify qualifications:

- ☑ **Other**

  Specify the individuals and their qualifications:

  The waiver participant and/or representative will direct the development of the Participant Centered Spending Plan (PCSP) with the assistance of the consultant.

  Consultant qualifications are as follows:
  Staff responsible for working with participants to develop PCSPs shall meet the minimum qualifications. To function as a Consultant the minimum qualifications are: A Bachelor's degree in social services, human services, behavioral sciences, or an allied field, and three years of paid social service experience performing functions equivalent to a Social Worker or Case Manager; or a Bachelor's degree with two years experience in the coordination or provision of Independent Living or comparable services. Additional related experience may be substituted for the basic requirements on a case by case basis.

  The Consultant must have relevant experience providing services and supports for vulnerable adult populations. The Consultant should have experience with Medicaid HCBS or similarly funded service delivery systems.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

- ◉ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
- ○ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

  The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

(a) Consultants provide information about the waiver verbally, through written materials, or through alternative communication modes adapted to participant need. Initial visits are used for review of New Freedom programmatic and financial features. Consultants review the allowable uses of the monthly budget, and help participants think about what supports and services will be included in the PCSP. Participants have the authority to determine the level of assistance provided by the consultant beyond the minimum requirement of orientation to the waiver, and development and review of the PCSP.

At the time of assessment, case managers review the "Client's Rights and Responsibilities (DSHS 16-172)" document with clients that outlines their right to participate in the development of their plan of care and ensure that their preferences and the services they wish to receive are included in their plan of care. The Client's Rights are:

As a client of Aging and Disability Services Administration, you have a right to:
• Be treated with dignity, respect and without discrimination;
• Not be abused, neglected, financially exploited, abandoned;
• Have your property treated with respect;
• Not answer questions, turn down services, and not accept case management services you do not want to receive. However, it may not be possible for Aging and Disability Services Administration to offer some services if you do not give enough information;
• Be told about all services you can receive and make choices about services you want or don't want;
• Have information about you kept private within the limits of the laws and DSHS regulations;
• Be told in writing of agency decisions and receive a copy of your care plan;
• Not be forced to answer questions or do something you don't want to;
• Talk with your social service worker's supervisor if you and your social service worker do not agree;
• Request a fair hearing;
• Have interpreter services provided to you free of charge if you cannot speak or understand English well;
• Take part in and have your wishes included in planning your care;
• Choose, fire, or change a qualified provider you want; and
• Receive the results of the background check for any individual provider you choose.

The "Medicaid and Long Term Care Services for Adults (DSHS 22-619)" brochure is given to all new clients at initial assessment. This document outlines Medicaid eligibility and long term care services available.

(b) PCSP development always includes the client and their legal representative (if applicable). Clients may include any other individuals of their choice to participate. ADSA encourages participants to include family and other informal supports as appropriate to the participant's situation.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and

monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

(a) who develops the plan, who participates in the process, and the timing of the plan;

The Participant Centered Spending Plan (PCSP) is developed at the direction of the participant. Others involved in the development of the plan include the New Freedom consultant, the participant's legal representative (if applicable), and any others invited by the participant such as family members, and other informal supports. Planning meetings are scheduled by the participant at times and in locations that are convenient for the participant and others she/he has invited to the meeting.

The PCSP is developed after the participant's service needs have been identified through the comprehensive assessment using the CARE tool. Comprehensive assessments are conducted in the participant's home at a time convenient to the participant. After the comprehensive assessment has been completed, an interim PCSP can be put into place to provide services needed immediately. This plan is developed by the participant, consultant and others and is intended to ensure that needed services such as personal care are put into place without delay. The interim plan can be in place up to 30 days, by which time the final PCSP must be completed.

(b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status;

Case managers conduct assessments using the CARE automated assessment tool. CARE leads the case manager and client systematically though a series of assessments covering multiple life domains. Assessment items are based on the Minimum Data Set (MDS) and all areas include client preferences, limitations and caregiver instructions.

Assessment areas include demographics, collateral contacts, formal and informal supports, caregiver status which includes the Zerit burden scale to assess provider burden, behavioral issues, psychosocial and legal issues. Medical assessment includes diagnoses, ability to manage medications, treatments, both skilled and unskilled, mobility and toileting.

Care assesses indicators of medical risk including number of hospitalizations, skin breakdown, history of routine and preventive medical care, medication regimen and multiple diagnoses.

CARE Screens and assessment elements:
-Client demographics including: collateral Contacts, Caregiver Status, Financial eligibility, Employment status and goals.

-Medical and health status: Current Medications and Medication Management, Diagnoses, Treatments both skilled and unskilled, Indicators of risk such as recent hospitalizations, skin problems, pain, lack of preventive care (mammograms, PSA, Colonoscopy, etc.), significant change in self sufficiency, Communication skills and resources, Ability to use the phone, vision, speech, and hearing abilities, mobility and history/risk of falls.

-Psychosocial assessment: MMSE, Memory, Each current or past behavior and successful interventions, depression, Suicide risk, Sleep patterns, Relationships and Interests, Decision Making, Client goals, Alcohol, tobacco and substance abuse.

-Legal Issues - Any legal matters concerning the client including: Risk of abuse, neglect, and/or exploitation, No contact or protection orders, Less restrictive order, Guardianship, Power of Attorney, Advanced Directives, Divorce proceedings, Eviction, Involuntary commitment, Lawsuits, Parole or probation, Pending civil or criminal proceedings.

-Activities of Daily Living including: Toileting, Nutritional/Oral status, Bathing, Dressing, Personal Hygiene, Household Tasks, Transportation, Shopping, Wood Supply if wood is the sole source of heating or cooking, Housework, Assessing for environment modifications and/or assistive equipment.

(c) how the participant is informed of the services that are available under the waiver;

At the time of the comprehensive (CARE) assessment, case managers provide and review with all individuals interested in services the Medicaid and Long-Term Care Services for Adults brochure (DSHS 22-619X). This booklet outlines the services, resources, and options available through ADSA including waiver options. This booklet includes

several links to information about services and resources for individuals who have internet access. Additional information about the New Freedom waiver is made available to eligible individuals in King County. The New Freedom consultant reviews programmatic and financial features of the waiver. Consultants review the allowable uses of the monthly budget, and help participants think about what supports and services will be included in the spending plan.

(d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences;

Participants identify their personal goals and planned outcomes in relation to their assessed needs. The consultant gathers additional information about the person's needs, preferences, and goals by engaging with the individual and trusted others. Participants then determine the services they will purchase based on their preferences and priorities and develop their service budget accordingly. Consultants can guide conversations and help participants clarify desired outcomes and strategies for meeting them. They help identify risks and develop plans for supports related to those risks. Participants will include plans for emergency back-up personal care services. The plans include descriptions of safeguards necessary to reasonably address the individual's health and welfare, and a plan for meeting the emergency needs of the participant.

(e) how waiver and other services are coordinated;

The PCSP documents the participant's goals in relation to the needs identified in the CARE assessment and the subsequent services and goods that will be acquired. The plan includes services and goods acquired through sources other than the waiver, with a description of how waiver services are coordinated with non-waiver services.

(f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan

The plan service to be provided and identifies the provider who will deliver the service or item. Consultants review the Participant Service Budget received from the Financial Management Service (FMS) monthly to ensure that the participant is receiving the services/goods identified in their PSP in a timely manner. The Consultant provides technical assistance to the participant regarding managing their budget and problem solve as needed.

Plans include projected expenditures for each purchase. The FMS ensures that all expenditures are for services identified in the PSP and that the expense can be covered by funds in the budget. Participants receive quarterly budget reports to monitor spending on their planned services. The FMS conducts regular reviews of the participant's budget and expenditures.

(g) how and when the plan is updated, including when the participant's needs change.

The PCSP is updated annually, when the participant adds or deletes a service, or when the participant budget changes as the result of a significant change assessment.

The participant or consultant may request a new CARE assessment if a significant change occurs in the participant's condition. Significant change is defined as a reported significant change, for better or worse, in the client's cognition, mood/behavior, ADL's or medical condition.

A reassessment due to a significant change may result in an increase or decrease in authorized care hours. Because care hours generated through the assessment are converted to the budget amount available for participant direction, a change in hours will result in a change in the budget amount.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant

needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Each participant directs the development of their individual PCSP including review of all critical risk indicators identified in the CARE assessment. CARE requires individualized risk analysis as a part of the assessment process. A backup plan from the limitations list on automated CARE screen is selected and the case manager uses the comment box to add client specific information and a back-up caregiver is identified on the Collateral Contact screen. Every plan of care must include an evacuation plan. If evacuation without assistance is difficult or impossible the case manager and client discuss the risks involved and possible outcomes. The case manager discusses long term care settings that may meet the individual's needs and reduce risk. If the individual chooses to stay at home, the case manager documents the client's decision.

Back up plans are discussed and planned for during the development of the PCSP. The Consultant assists with alternatives such as using a Home Care Agency or locating a back up provider.

Exception to Rule (ETR) requests may be submitted if the budget generated by the CARE algorithm does not meet the participant's care needs. Managers of statewide HCS programs conduct team review of ETR's weekly. ETR approvals are based on the clinical characteristics and specific care needs of the participant. ETR requests may also be submitted when a participant has an immediate need to purchase a good or service that cannot be purchased under the participant's budget.

During development of the PCSP, the participant weighs the cost-benefit of a potential risk, decides what level of risk to assume and develops a plan to manage it. The strategies and steps to address known critical risks are documented in the PSP and are tied to the plans for backup services that are also documented in the PCSP. In opting for New Freedom consumer directed services the participant assumes responsibility for contacting the consultant if the participant believes her/his needs are not being met or safety and well being are compromised.

Adult Protective Service staff and New Freedom consultants coordinate with each other for participants who experience or are at risk of abuse, abandonment, neglect, self-neglect or exploitation. The comprehensive assessment identifies individuals with challenging behaviors and documents intervention strategies for each behavior. Individual and Agency Providers must successfully complete Department required training in order to provide personal care services.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

Participants are given free choice of all qualified approved providers of each service included in his or her PCSP. Consultants provide orientation to participants regarding allowable expenditures, and advise participants on accessing services and goods identified in the PCSP. Participants are able to access Information and Referral entities to obtain listings of available providers (those other than Individual Providers providing personal assistance services).

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

ADSA determines client eligibility and requires the use of the department's electronic assessment and service planning tool. ADSA case managers complete the initial comprehensive assessment and LOC determination. For Participants enrolling in New Freedom, subsequent annual assessments and LOC determinations are completed by case managers of the contracted case management agency and Participant Centered Spending Plans (PCSPs) are completed by the Consulting agency. ADSA has direct electronic access to all comprehensive assessments.

A random sample of PCSPs is reviewed by an ADSA quality monitoring team on a 24 month cycle. The sample size is calculated using a statistically valid method to arrive at a confidence Level of 95 percent with a confidence interval of +/- 5%.

Quality assurance processes may result in corrective actions, adjustments to training curriculum, policy clarifications, forms revision, WAC revisions and targeting criteria for the next review cycle.

Full details regarding the frequency of reviews, review methodology, and roles and responsibilities are outlined in Appendix H.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ◉ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

  Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

- ☐ **Medicaid agency**
- ☐ **Operating agency**
- ☐ **Case manager**
- ☑ **Other**

  Specify:

  The Consultant Support Services agency

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

(a) New Freedom Consultants have primary responsibility for monitoring the implementation of the PCSP.

(b) Consultants facilitate review of the plan by helping participants identify what is working and what needs to change in order to attain the participant's goals. Participants are encouraged to invite trusted others to participate in the discussion. Consultants work with participants to determine whether the plan outcomes result in health and well being, that services are furnished consistent with the plan goals and that back-up plans are reviewed for effectiveness and revised accordingly. Consultants assist participants to develop strategies to address any barriers or preference issues associated with access to waiver and non-waiver services. Consultants review the Participant Service Budget (PSB) received from the Financial Management Service (FMS) monthly to ensure that the participant is receiving the

services/goods identified in his/her PCSP in a timely manner. The CSS will provide technical assistance to the participant regarding managing the budget and problem solving as needed.

Consultant contacts include a discussion with the participant about access to services and service providers including non-waiver services. When problems are identified, the consultant assists the participant to develop a plan to more closely monitor that needs are being met. When needed, consultants initiate contracts with additional providers to provide services identified in the PCSP and to offer choice to the participant. Consultants also assist with referrals to non-waiver services and help participants identify providers of non-waiver services such as healthcare providers.

Consultants coordinate with case managers when there is an identified significant change with the participant's care needs that would warrant a reassessment in CARE or when budget changes occur.

(c) At a minimum, consultants have yearly face to face visits with participants and make contact with the participant at least quarterly to review and make any changes that may be needed to the plan and/or budget.

b. Monitoring Safeguards. *Select one:*

- (●) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- ( ) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant**

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
The percentage of Participant Centered Spending Plans (PCSP) for waiver participants that address their assessed needs and personal goals by the provision of waiver services or other means. N= Number of PCSPs reviewed that address all assessed needs and personal goals D= Number of PCSPs reviewed

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
☑ State Medicaid Agency	☐ Weekly	☐ 100% Review
☐ Operating Agency	☐ Monthly	☑ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☑ Representative Sample Confidence Interval = 5%
☐ Other Specify:	☐ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☑ Other Specify: 24 months	

Data Source (Select one):
Other
If 'Other' is selected, specify:
Administrative Data

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
☑ State Medicaid Agency	☐ Weekly	☑ 100% Review
☐ Operating Agency	☑ Monthly	☐ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☐ Representative Sample Confidence Interval =
☐ Other Specify:	☑ Annually	☐ Stratified Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: 24 months

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percentage of Participant Centered Spending Plans (PCSP) completed within 30 days of referral N= Number of PCSP completed within 30 days of referral D= Number of PCSPs reviewed

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for	**Frequency of data**	**Sampling Approach**

data collection/generation *(check each that applies):*	**collection/generation** *(check each that applies):*	*(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: 24 months	

Data Source (Select one):
Other
If 'Other' is selected, specify:
Administrative data

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and**	☐ **Other**

	Ongoing	Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: 24 months

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percent of PCSPs reviewed and updated prior to annual review date N= Number of PCSPs reviewed and updated prior to annual review date D= Number of PCSPs reviewed

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

(check each that applies):		
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: 24 months	

Data Source (Select one):
Other
If 'Other' is selected, specify:
Administrative data

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: 24 months

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percent of PCSPs where services were delivered as authorized N=Number of PCSPs where all authorized services were delivered D=Number of PCSPs reviewed

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: 24 months	

Data Source (Select one):
Other
If 'Other' is selected, specify:
Administrative data

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

☐ **Other**
Specify:

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: 24 months

e. ***Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percent of participants that choose between waiver services and institutional care.
N=Number of waiver participants that signed an Acknowledge of Services document D= Number of waiver participants reviewed

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**

☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: 18 months	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percent of signed PCSPs that indicate client choice of provider and services N=
Number of approved PCSPs that indicate client choice of provider and services D=
Number of approved PCSPs reviewed

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data	**Frequency of data collection/generation**	**Sampling Approach** *(check each that applies):*

collection/generation *(check each that applies):*	*(check each that applies):*	
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: 24 months	

Data Source (Select one):
Other
If 'Other' is selected, specify:
Administrative data

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: 24 months

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

HOW THE PARTICIPANT CENTERED SPENDING PLAN IS DEVELOPED (BACKGROUND)
The Participant Centered Spending Plan is developed after a comprehensive assessment has been completed using the CARE assessment application. The comprehensive assessment is based on information entered into CARE by the participant and case manager during the assessment process. CARE tracks identified needs and whether providers (formal or informal) are assiting with these needs. CARE has the case manager address/plan for each topic as he/she moves through the assessment process.
The PCSP identifies areas such as:
- Formal and informal supports, which hours have been assigned to each and their schedules;
- Participant goals and preferences; and
- Referrals (who will follow through with the referral and when)

HOW DISCOVERY IS DESIGNED AND IMPLEMENTED
Statewide ADSA QA Unit Discovery Activities
An ADSA quality team monitors participant plans using a statistically valid sample of records statewide on an 18 month review cycle. Preliminary analysis is available annually.
- QA reports are reviewed and corrective action taken on an on-going basis throughout the review cycle by the Consultant Support Services entity. Consultants are required to take action within specified time frames to address all problems identified in PCSPs during the QA monitoring.
- All participants assessed needs (including health and safety and risk factors) whether or not paid by ADSA, are addressed in the PCSP.
- Evacuation plans are required
- If lack of immediate care would pose a serious threat to the health and welfare of the participant, a backup plan is required.
- QA monitoring assures that all services are delivered in accordance with the service plan, including type, scope, amount, duration, and frequency as specified in the plan of care.

The QA monitoring data and CARE reports, (QA monitoring data is current at the time monitoring occurred and CARE management reports are in real time), capture the following:
- Needs identified in CARE are adequately addressed in the participants PCSP
- PCSP development is participant directed and plans are completed in required time frame
- Participants receive all of the services identified in the PCSP
- Participants are provided the freedom to choose waiver services, institutional care, and service providers.
- Plans are reviewed and revised in response to participant direction or change in needs.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

Upon completion of each record review, the consultant is expected to make necessary corrections. Corrections are verified by either the QA team or the consultant's supervisor. The QA team verifies that required corrections have been made at the individual level within 40 days of the preliminary review and documents the verification in the QA monitoring database. Items related to health and safety and payment, require either immediate action or within three working days depending on the situation. Supervisors verify that corrections have been made at the individual level prior to completing the review and document this activity in the QA database.

Reports and aggregate data are reviewed throughout the year (based on an established review schedule) by individuals who make decisions on what improvements are needed individually or systemically. Corrective action plans must be developed within 40 day of receiving the final report. Corrective action plans address any area where proficiency was less than 100%. Draft plans are reviewed by ADSA prior to approval and implementation. Progress reports are produced every six months. Systemic issues are addressed in on-going training, policy review/revision/development, and other areas as needed.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: 18 months

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

- (●) **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- ( ) **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

- ( ) **Yes. The State requests that this waiver be considered for Independence Plus designation.**
- (●) **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

(a) the nature of the opportunities afforded to participants:
New Freedom waiver participants have the opportunity to fully direct all waiver services. Participants work within a budget allotment that is calculated based on their comprehensive assessment. Through this allotment, participants plan for and purchase all necessary goods and services to meet their assessed needs. Participants have both budget and employer authority in the New Freedom waiver.

(b) how participants may take advantage of these opportunities:
Each participant develops a Participant Centered Spending Plan which addresses the needs identified in the comprehensive assessment. The PCSP identifies which goods and services will be purchased to meet the assessed needs and the qualified provider of each good and service.

(c) the entities that support individuals who direct their services and the supports that they provide:
Consultant Support Services support participants in developing and implementing the PCSP. The CSS assists the client in identifying and locating qualified providers and provides training and support to manage providers. Consultants provide orientation to participants about waiver requirements and participant responsibilities; review initial spending plan and subsequent revisions; maintain contact with participants for the first six months, as needed thereafter and at least annually. Optional supports provided by the consultant include training and support to assist participants in developing spending plans; information related to recruiting and supervising individual's providers; and assistance in identifying equipment and services.

Financial management services are provided for all individual provider tasks related to payment of services, payment of other services and goods, providing participants with flexible mechanisms to expedite preferred purchases, conduct criminal background checks , contracting activities related to providers of waiver services and providing participants with quarterly budget statements.

Case management services conduct comprehensive assessments annually and more frequently when significant change occurs and conduct annual eligibility and LOC reviews. Nursing services are also provided through the case management entity.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

- ○ **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ○ **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ◉ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

- ☑ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- ☐ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- ☐ **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one):*

- ◉ **Waiver is designed to support only individuals who want to direct their services.**
- ○ **The waiver is designed to afford every participant (or the participants representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
- ○ **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. **Information Furnished to Participant.** Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

(a) Printed material is available about participant direction through the New Freedom Waiver. This material details the rights and responsibilities of New Freedom participants and describes the benefits and challenges, including possible liabilities such as hiring, firing and recruiting providers of personal care and arranging for back up providers, of participant-direction. This material is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction. In addition to printed material case managers, social workers and consultants are available to personally discuss these aspects of participant direction in the New Freedom waiver. This information is also included on the public ADSA internet site.

(b) Case managers, social workers and consultants provide information about participant direction to all interested individuals.

(c) Information about participant direction is included in the information provided to individuals inquiring about services in King County.

At the time of the comprehensive CARE assessment, case managers/social workers inform individuals (and/or representatives) of waivers that are available to them, including the New Freedom waiver, and the services, benefits and responsibilities in each program.

Case managers also provide this information at the request of participants currently enrolled in other waiver programs.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. **Participant Direction by a Representative.** Specify the State's policy concerning the direction of waiver services by a representative *(select one):*

- ○ **The State does not provide for the direction of waiver services by a representative.**
- ◉ **The State provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

- ☑ **Waiver services may be directed by a legal representative of the participant.**
- ☑ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

The participant or their representative acting in conjunction with the participant direct the development and implementation of the PCSP. Representatives who direct waiver services may not be paid providers of waiver services.

The participant identifies a friend, family member, neighbor or community resource to act as their representative. Representatives and their contact information are entered in the Department's assessment. Representatives in conjunction with the participant make decisions involving:
•Recruit staff
•Select staff from worker registry
•Hire staff common law employer

•Specify additional staff qualifications based on participant needs and preferences
•Determine staff duties based on needs identified in the Department's assessment
•Notify the Department if the participant's needs are not being met
•Orient and instruct staff in duties
•Evaluate staff performance
•Verify time worked by staff and approve time sheets
•Discharge staff (common law employer)

At time of assessment a plan is developed identifying how direction will occur by the representative in order to assure that the representative is functioning in the best interest of the participant. Care planning safeguards may include arrangement for::
•A reliable informal caregiver to identify when problems with care exist.
•Authorization of more than one provider to provide care so that there is an "additional set of eyes" in the client's home which provides additional monitoring that representatives are functioning in the participant's best interests.
•other services such as authorization of home delivered meals or adult day care
•More frequent Consultant contact with the client.
•Periodic contact with other professionals.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Participant-Directed Waiver Service	Employer Authority	Budget Authority
Environmental and Vehicle Modifications	☑	☑
Treatment and Health Maintenance	☑	☑
Training and Educational Supports	☑	☑
Personal Assistance Services (PAS)	☑	☑
Individual Directed Goods, Services and Supports	☑	☑

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i)*.

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☑ **Governmental entities**
☑ **Private entities**

○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

- **FMS are covered as the waiver service specified in Appendix C1/C3**

  The waiver service entitled:

- **FMS are provided as an administrative activity.**

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

The State Medicaid Agency and a private Financial Management agency provide FMS services.

The Financial management agency was procured for administrative functions through a standard State of Washington solicitation process in accordance with applicable regulations at 45 CFR §74. A Request for Proposal (RFP) was published nationally and all organizations with capacity to meet all requirements outlined in the RFP were evaluated by a review panel which recommended the successful candidate.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

FMS are paid on a per-participant basis from administrative funds. The per member/per month rate is a flat rate paid to the contracted FMS agency to cover all activities performed for the participant and does not vary according to type of activity performed. The FMS receives payment for each month in which the participant is enrolled in the waiver for any portion of the month. The FMS has access to the Department's Social Service Payment System (SSPS) through which payments to Individual Providers of personal care are authorized. The FMS is required to have an accounting system in place that is capable of performing all required financial transactions and is contractually obligated to use a certified public accountant or an individual with a baccalaureate degree in accounting on staff or under contract to ensure that accounting standards are used. In addition, to an annual independent audit, ADSA provides periodic monitoring of the FMS documentation and accounting systems.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

- **Assists participant in verifying support worker citizenship status**
- **Collects and processes timesheets of support workers**
- **Processes payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
- **Other**

  Specify:

  Conducts criminal background checks.
  Implements the contracting process with Individual Providers at the direction of the participant.
  Implements the contracting process for other providers of waiver services as applicable.

Supports furnished when the participant exercises budget authority:

- **Maintains a separate account for each participant's participant-directed budget**
- **Tracks and reports participant funds, disbursements and the balance of participant funds**
- **Processes and pays invoices for goods and services approved in the service plan**

☑ **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
☐ **Other services and supports**

Specify:

Additional functions/activities:

☑ **Executes and holds Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
☑ **Receives and disburses funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
☑ **Provides other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget**
☑ **Other**

Specify:

Provides participant specific expenditure reports on a quarterly basis as required by the Medicaid agency.

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

(a) The State Aging and Disability Services Administration coordinates monitoring FMS performance to ensure that policies and procedures are in place that assure adherence to state and federal regulations, and that practices are in accordance with established contractor performance standards. This includes monthly review of FMS payment data, identification of payment issues, and follow-up to ensure payment corrections are made. Claims submitted by the FMS must correspond with services, amounts, time frames, etc. as authorized in the PCSP. Payment system reports which provide data on participant service use and costs are utilized in monitoring.

The consultant is responsible for verifying expenditure requests are congruent with the PCSP. The FMS generates a quarterly statement of expenditures and balance for review by the participant, consultant and waiver manager.

Both consultants and financial management services track and report consumer comments/feedback(excluding comments classified as complaint or allegation which require immediate follow-up per statute) along with routine information about the number of people served in each function and the general patterns of expenditures, by type and benefit category on a quarterly basis. The FMS generates a quarterly statement of expenditures and balance for the participant, consultant and waiver manager.

The FMS must maintain records to track all waiver expenditures including time records of people paid to provide supports and receipts for any goods purchased, invoices, and cancelled checks. The records must be maintained for a minimum of five years from the claim date and must be available for audit or review upon request. The FMS must also receive a copy of the recipient's Participant Centered Spending Plan. Claims submitted by the FMS must correspond with services, amounts, time frames, etc. as authorized in the PCSP.

(b) The participant, consultant, New Freedom Program manager all have a role in monitoring the performance of the FMS agent.

(c) New Freedom program manager monitoring occurs monthly. Utilization and enrollment reports from the New Freedom consultant and financial management services include spending plans, costs reports, and narratives regarding challenges and successes of implementation and are provided quarterly.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☐ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

☐ **Waiver Service Coverage.** Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Environmental and Vehicle Modifications	☐
Treatment and Health Maintenance	☐
Training and Educational Supports	☐
Personal Assistance Services (PAS)	☐
Individual Directed Goods, Services and Supports	☐

☑ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

(a) The types of entities that furnish these supports;
Information and assistance in support of participant direction are furnished by both Consultant Support Services and Financial Management Services.

(b) How the supports are procured and compensated;
The Financial Management and Consultant Support Services were competitively procured. They are paid on a fee per client per month basis.

(c) Describe in detail the supports that are furnished for each participant direction opportunity under the waiver;
Consultants assist participants to make informed decisions about services and supports that are consistent with their assessed needs, and reflect individual circumstances. Consultants guide and facilitate planning, and assist participants in identifying options to carry out the goals of the spending plan, and assist with plan revisions. Consultants offer orientation and information about waiver requirements, participant responsibilities, and managing the supports and services identified in the plan. Consultants provide training to waiver participants about participant responsibilities as employers of their individual providers. This training includes information about recruitment, hiring/dismissal, qualifications, duties, scheduling, orientation, supervision, evaluation, and training about signing and retaining time sheets. Written information about these topics is also available from

the SMA and is provided to participants who employ individual providers.

The Financial Management Service provides necessary payroll and other employment functions. The FMS collects and stores the payment data and provider wage information required by federal and state rules. The FMS assists in the recruiting, background checks, and contracting of individual providers of direct personal care services, and helps locate and develop resources for other supports/services. The FMS manages contracts with waiver service providers. At the direction of the participant, FMS initiates payment for waiver services. The FMS tracks individual budget expenditures and prepares and submits quarterly statements to the participant.

(d) The methods and frequency of assessing the performance of the entities that furnish these supports;
Performance of the CSS and FMS is evaluated through annual contract monitoring. Contract monitoring includes a review of a statistically valid sample of client records and a review of waiver provider contracts and all pertinent FMS and CSS records, policies and procedures.

(e) The entity or entities responsible for assessing performance:
Contract monitoring is conducted by staff of the SMA.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one)*.

- **No. Arrangements have not been made for independent advocacy.**
- **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

The participant, representative or consultant, as requested by the participant, will notify the Consultant of the participant's desire to terminate New Freedom Waiver services. Participants who voluntarily terminate their enrollment in New Freedom are able to transition to services available through the State Plan or another waiver when they meet eligibility standards. Case management staff will implement the service plan generated at the comprehensive assessment, or if there is a significant change in the person's condition, will complete a new assessment and service plan. Participants who transition to another waiver or State Plan personal care will be able to continue with the same personal care providers if preferred.

For participants who are no longer eligible for waiver services, case management provides transition supports to promote continuity of services and participant health and welfare will be provided and are described in detail in ADSA's Long Term Care Manual-Chapter 5. These supports include, termination planning with the participant, supportive functions including participant advocacy, technical assistance, referrals for services and family support.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provide-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

When the Consultant determines that a participant does not have the capabilities to be enrolled or to continue enrollment in a participant directed model of care the Consultant may ask for an involuntary disenrollment.

The Consultant will draft a written notice to the participant that documents the one or more of the requirements for involuntary disenrollment/denial of enrollment and forward the notice to the NF Program Manager for approval/denial prior to sending it to the Participant. In addition to the disenrollment/denial letter, the Consultant will send the NF Program Manager accompanying documentation of what efforts have been made to help the Participant to be successful in the program.

The NF Program Manager will notify the Consultant and case manager responsible for the annual assessment of the outcome of the request for disenrollment/denial within 15 days of receipt. If approved the Consultant will send the disenrollment/denial letter to the participant and include the disenrollment date which will be provided by the NF Program Manager. For involuntary disenrollments the letter must contain language that the participant will not be losing all long-term care services, but will be transferring back to the appropriate fee-for-service waiver or State Plan program.

The case manager will send the participant a PAN noting the New Freedom disenrollment and the new state plan, waiver or other program that the Participant will be receiving.

Participants who transition to another waiver or State Plan personal care will be able to continue with the same personal care providers if preferred. Case management staff will implement the service plan generated at the comprehensive assessment, or if there is a significant change in the person's condition, will complete a new assessment and service plan.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1		800
Year 2		1281
Year 3		2051
Year 4 (renewal only)		3283
Year 5 (renewal only)		5256

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

☐ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

☑ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-Approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

☑ **Recruit staff**
☐ **Refer staff to agency for hiring (co-employer)**
☐ **Select staff from worker registry**
☑ **Hire staff common law employer**
☐ **Verify staff qualifications**
☐ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

☑ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**
☑ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
☐ **Determine staff wages and benefits subject to State limits**
☑ **Schedule staff**
☑ **Orient and instruct staff in duties**
☑ **Supervise staff**
☑ **Evaluate staff performance**
☑ **Verify time worked by staff and approve time sheets**
☑ **Discharge staff (common law employer)**
☐ **Discharge staff from providing services (co-employer)**
☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

- [x] **Reallocate funds among services included in the budget**
- [x] **Determine the amount paid for services within the State's established limits**
- [x] **Substitute service providers**
- [x] **Schedule the provision of services**
- [x] **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- [x] **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- [x] **Identify service providers and refer for provider enrollment**
- [x] **Authorize payment for waiver goods and services**
- [x] **Review and approve provider invoices for services rendered**
- [ ] **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

The Comprehensive Reporting and Evaluation (CARE) tool is used to capture and classify the needs and resources of waiver participants. The information gathered in CARE is used to determine assistance levels based on the following characteristics: clinical complexity, behavior/mood, cognitive ability, activities of daily living, informal supports. Based upon the combination of these factors, each person is placed in one of seventeen levels of acuity related classification for funding. In New Freedom, these levels are the basis for the determination of the individual budget with a payment add-ons, and historical data on costs of units of service, translated into current spending levels for other New Freedom waiver services. The New Freedom participant guide book explains that the participant budget is determined by the participant's CARE assessment and offers information to the participant about the need to prioritize and select services to create a budget spending plan that does not exceed available resources. This information is pubicaly available to all interested parties in

Washington Adminitrative Code.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

iii. Informing Participant of Budget Amount. Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Case managers/social workers inform participants of the budget amount at the time of assessment. Adjustments in the budget amount will occur under the following circumstances, a) the spending plan includes personal care provided by a home care agency, b) the spending plan includes environmental modifications or assistive technology that cannot be covered in the budget, and c) the participant's condition or situation changes. Participants who disagree with the outcomes of the CARE assessment have rights to a Fair Hearing.

Participants may request an adjustment to the budget through the Exception to Rule (ETR) process. ETR requests are evaluated by determining whether the participant's situation differs from the majority. Managers of statewide HCS programs conduct team review of ETRs weekly and when granting or denying an adjustment to the participant's budget consider whether care needs are exceptional and/or there is an immediate need for a good or service that cannot be purchased within the participant's available budget.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

iv. Participant Exercise of Budget Flexibility. *Select one*:

- ○ **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ◉ **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

The participant may make revisions to expenditures when such changes do not substantially alter the plan. Revisions that significantly alter the plan outcomes or redirect substantial budget amounts must be preceded by the review of the consultant entity to determine if changes in the services plan are required to meet the desired changes chosen by the participant. Substantial alteration of the plan is considered equal or greater than ten percent of the annualized value of the person centered spending plan.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the

premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Each person's Participant Centered Spending Plan is tracked by the FMS on a database. When the plan is developed the participant prioritizes needed purchases and the order in which they will be purchased is recorded in the database. When the participant has accumulated the needed funds the purchase is made and the balance is readjusted. The FMS will not make payments unless the following conditions have been met:
-the item or service is included in the PCSP
-the budget balance is sufficient to cover the expenditure
-the participant has approved the payment
-appropriate receipts have been provided to the FMS
The participant receives quarterly reports listing their account balance and expenditures. The participant and the CSS can request a balance at anytime for on-going planning purposes.

The FMS supplies quarterly reports to each participant and the CSS which include the account balance. The CSS reviews the report for underutilization and works with the participant to address any service delivery problems that may be contributing to this such as difficulty locating a provider or payment issues. In addition, the FMS reviews all monthly time sheets for Individual and agency personal care providers and compares utilization against the monthly budget allotment for this service. Under utilization is reported to the CSS which works with the participant to address any issues preventing utilization of the service.

The ADSA Program Manager receives monthly reports from the FMS which list the account balance and utilization of each New Freedom Waiver service for all participants. These reports are used to monitor utilization of waiver services and address concerns with the FMS and CSS.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

All individuals assessed for this program have fair hearing rights as specified in the Medicaid state plan. A pamphlet describing the rights and process is included with every Medicaid application and again during the assessment process. Fair hearing information is also contained in the DSHS document 14-225, Acknowledgment of Services, which the participant signs to indicate understanding of their rights to choice in waiver services and fair hearings.

Fair hearing policies and corresponding State regulations ensure that all persons have the right to apply for Long-term Care (LTC) services administered by the department, and all applicants/clients have the right to have their financial and program eligibility determined by the department, the right to appeal any decision which they perceive as adversely impacting the authorization or delivery of LTC services including, but not limited to the denial of services, reduction in the level of services, suspension of services, or termination of service. Fair Hearing Policy and Procedure is outlined in Chapter 1 on the State Long Term Care Manual. Implementation and tracking of Fair Hearings is accomplished through an automated database.

The following steps provide a general outline to describe the how the individual or his/her legal representative is informed of the opportunity to request fair hearing and the process used when there is a disagreement:

The New Freedom Consultant:
- Informs the individual informally AND in writing of adverse actions through a Planned Action Notice (PAN) when a

service or choice of provider is denied, suspended, reduced, or terminated and explains the reason(s) for the action or decision in question, including the facts upon which the decision was based. The same process will be followed if (as described in Appendix E) a participant who has chosen HCB waiver services over institutional services may no longer be safely served on the waiver. The individual must always be informed of the right to a fair hearing and how to make a fair hearing request. A fair hearing request form is included with the notification letter sent to the client. Planned Action Notices are currently retained in the client's record. Decisions are kept with the same retention schedule as other client documents. The case manager:

- Attempts to resolve the issue when an individual does not agree with the decision/action taken. Explores alternatives such as an Exception to Rule (ETRs), when appropriate, or the availability of other programs or services, including services or assistance which may be offered by other community social service agencies. This is the initial step in the voluntary pre-hearing process

- Asks the individual if he/she wants to request a fair hearing when the issue cannot be resolved;

- Advises, and may assist, the applicant/client to complete a Request for Fair Hearing (DSHS 08-013(x) when the client chooses to make a formal request, and submits it to the Office of Administrative Hearings .Fair hearing requests may be made verbally, as well as in any written format. When received, the Office of Administrative Hearings must be contacted to formalize the request. This may be done by the social worker/case manager, the fair hearing coordinator (FHC), or any representative of the department who receives the fair hearing request from the individual.

- Notifies the local Fair Hearing Coordinator of the client's fair hearing issue

- Informs the client of eligibility for continued benefits, pending the outcome of the FH. The decision about eligibility for continued benefits is determined with the FHC;

- Notifies the client that benefits must be repaid if the outcome of the FH finds in favor of the department. The client has the choice of whether to receive continued benefits pending the outcome of the fair hearing.

- Documents in the Service Episode Record (SER) the date, topic of discussion, that the fair hearing process has been explained; and the client's decision.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The State operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- **No. This Appendix does not apply**
- **Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the State agency that is responsible for the operation of the grievance/complaint system:

The system is operated by the Medicaid Agency through the Aging and Disability Services Administration.

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Describe the grievance/complaint system, including:
(a) The types of grievances/complaints that participants may register;
Participants may register complaints about anything the Department does or is responsible for that they perceive as affecting them negatively in any way. To protect participant rights, some types of complaints are immediately directed to other formal systems rather than being addressed through the grievance process.

All participants receive the document, "Your Rights and Responsibilities When You Receive Services Offered by Aging and Disability Services Administration". This document informs participants that they have the right to make a complaint and also have the right to separately file a Fair Hearing. In addition, participants receive a Planned Action Notice informing them of all actions taken by ADSA. This notice outlines the Fair Hearing process and offers participants the pamphlet entitled "Your Hearing Rights in a DSHS Case". The pamphlet, "Your Hearing Rights in a DSHS Case", explains that an optional opportunity to settle the case before the hearing is available and also explains that if an agreement cannot be reached the right to a Fair Hearing remains.

Complaints not handled through the grievance process include the following:

a. Complaints of abuse, neglect or financial exploitation of a vulnerable adult or child - referred to formal protective systems
b. Client disputes about services that have been Denied, Reduced, Suspended, or Terminated - client is informed of their rights and referred to the fair hearing process
c. Complaints about possible Medicaid fraud - referred to the Medicaid Fraud Control Unit

(b) The process and timelines for addressing grievances/complaints;
Complaints can be received and addressed at any level of the organization. However, ADSA always strives to address grievances/complaints at the lowest level possible. Upon receipt at any level, all DSHS employees are required to respond to in-person or telephone complaints within 1 business day. Written complaints must receive a response within 7 business days. Complaints are referred to the case manager for action unless the complainant requests it not be. If the case manager is unable to resolve the complaint, the person is referred to the case manager's supervisor. The supervisor has ten working days from the date of receipt to attempt to resolve the issue. If the person feels their complaint is not resolved they are referred to the Regional Manager/AAA Director. The Manager/Director has ten working days to seek resolution. If the person continues to feel their complaint is not resolved, they are referred to the state level ADSA headquarters. ADSA has ten working days to resolve the complaint and must notify the person in writing of the outcome. All steps in this process are logged.

As part of the pre-hearing process, the administrative hearing coordinator is responsible for clarifying the issues that the client is disputing. If the dispute is in relation to a personality conflict with the case manager, for instance, or a dispute that falls outside of WAC/eligibility, the coordinator informs the client about their grievance procedure. A case manager, supervisor, etc. may also inform the client about the agency's grievance procedure. If the issue is the denial of an Exception to Rule request, the Notice of Action, Exception to Rule that is given to the client contains the grievance procedure.

(c) The mechanisms that are used to resolve grievances/complaints.

Mechanisms that are used as appropriate to the type of complaint may include record review and correction of any errors; case conferences with the client; a change of providers; information and referral; additional information on program policies, statutes, administrative rules; and adjustment to the plan of care.

References:

(1) ADSA Complaint/Grievance Policy for Home and Community Services Division and the Division of Developmental Disabilities
(2)Management Bulletin H05-018 – Policy/Procedure Client Grievance Policy March 2005
(3)DSHS Administrative Policy No. 8.11

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program.*Select one:*

- (●) **Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*

If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Reports of the abuse, abandonment, neglect, financial exploitation or self-neglect of a participant are received by Adult Protective Services by phone, fax, letter, or in-person.

References:

-RCW 74.34: Abuse of Vulnerable Adults statute
-WAC 388-71-0100 through 01280: Adult Protective Services
-HCS Long-Term Care Manual, Chapter 6, policies and procedures of the Adult Protective Services Program

Required reporting of allegations involving waiver participants: What, when and to whom:

RCW 74.34.035 Reports (excerpt):
(1) When there is reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred, mandated reporters shall immediately report to the department.

(2) When there is reason to suspect that sexual assault has occurred, mandated reporters shall immediately report to the appropriate law enforcement agency and to the department.

(3) When there is reason to suspect that physical assault has occurred or there is reasonable cause to believe that an act has caused fear of imminent harm:
(a) Mandated reporters shall immediately report to the department; and
(b) Mandated reporters shall immediately report to the appropriate law enforcement agency, except as provided in subsection (4) of this section.
(4) A mandated reporter is not required to report to a law enforcement agency, unless requested by the injured vulnerable adult or his or her legal representative or family member, an incident of physical assault between vulnerable adults that causes minor bodily injury and does not require more than basic first aid, unless:
(a) The injury appears on the back, face, head, neck, chest, breasts, groin, inner thigh, buttock, genital, or anal area;
(b) There is a fracture;
(c) There is a pattern of physical assault between the same vulnerable adults or involving the same vulnerable adults; or

(d) There is an attempt to choke a vulnerable adult.

Types of Abuse under RCW 74.34.020
"Abandonment" means action or inaction by a person or entity with a duty of care for a vulnerable adult that leaves the vulnerable person without the means or ability to obtain necessary food, clothing, shelter, or health care.

"Abuse" means the willful action or inaction that inflicts injury, unreasonable confinement, intimidation, or punishment on a vulnerable adult. In instances of abuse of a vulnerable adult who is unable to express or demonstrate physical harm, pain, or mental anguish, the abuse is presumed to cause physical harm, pain, or mental anguish. Abuse includes sexual abuse, mental abuse, physical abuse, and exploitation of a vulnerable adult which have the following meanings:

"Sexual abuse" means any form of nonconsensual sexual contact including, but not limited to, unwanted or inappropriate touching, rape, sodomy, sexual coercion, sexually explicit photographing, and sexual harassment. Sexual abuse includes any sexual contact between a staff person, who is not also a resident or client, of a facility or a staff person of a program authorized under Chapter 71A.12 RCW, and a vulnerable adult living in that facility or receiving service from a program authorized under Chapter 71A.12 RCW, whether or not it is consensual.

"Physical abuse" means the willful action of inflicting bodily injury or physical mistreatment. Physical abuse includes, but is not limited to: striking with or without an object, slapping, pinching, choking, kicking, shoving, prodding, or the use of chemical restraints or physical restraints unless the restraints are consistent with licensing requirements, and includes restraints that are otherwise being used inappropriately.

"Mental abuse" means any willful action or inaction of mental or verbal abuse. Mental abuse includes, but is not limited to: coercion, harassment, inappropriately isolating a vulnerable adult from family, friends, or regular activity, and verbal assault that includes ridiculing, intimidating, yelling, or swearing.

"Exploitation" means an act of forcing, compelling, or exerting undue influence over a vulnerable adult causing the vulnerable adult to act in a way that is inconsistent with relevant past behavior, or causing the vulnerable adult to perform services for the benefit of another.

"Financial exploitation" means the illegal or improper use of the property, income, resources, or trust funds of the vulnerable adult by any person for any person's profit or advantage.

"Neglect" means:
A pattern of conduct or inaction by a person or entity with a duty of care that fails to provide the goods and services that maintain physical or mental health of a vulnerable adult, or that fails to avoid or prevent physical or mental harm or pain to a vulnerable adult; or
An act or omission that demonstrates a serious disregard of consequences of such a magnitude as to constitute a clear and present danger to the vulnerable adult's health, welfare, or safety, including but not limited to conduct prohibited under RCW 9A.42.100.

"Self-neglect" means the failure of a vulnerable adult, not living in a facility, to provide for himself or herself the goods and services necessary for the vulnerable adult's physical or mental health, and the absence of which impairs or threatens the vulnerable adult's well-being. This definition may include a vulnerable adult who is receiving services through home health, hospice, or a home care agency, or an individual provider when the neglect is not a result of inaction by that agency or individual provider.

Required reporters of allegations of abuse, abandonment, neglect and financial exploitation are Washington State manadatory reporters as defined in statute as follows:

RCW 74.34.020 Definitions: (8) "Mandated reporter" is an employee of the department; law enforcement officer; social worker; professional school personnel; individual provider; an employee of a facility; an operator of a facility; an employee of a social service, welfare, mental health, adult day health, adult day care, home health, home care, or hospice agency; county coroner or medical examiner; Christian Science practitioner; or health care provider subject to chapter 18.130 RCW.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

The following resources illustrate ways that participants, family members, caregivers and/or legal representatives are provided information about protections from mistreatment and told how to report concerns or incidents of abuse, neglect, and exploitation:

Participants receive information from their case managers at least annually during their annual assessment or more frequently if their situation changes significantly and a reassessment is conducted. Every CARE assessment addresses potential abuse, neglect and exploitation. This information is provided by the case manager verbally and in ADSA publication, Medicaid and Options for Long-Term Care Services for Adults which is provided during the assessment.

At the time of assessment each participant reviews and signs a form entitled "Your Rights and Responsibilities"(including the right to be free from abuse…).

The participant financial eligibility process also includes a review of information on client financial rights.

Other resources available to participants and representatives include:
•Provider training (e.g., Caregiver Orientation, and Revised Fundamentals of Caregiving and Safety Training);
•ADSA and DSHS internet websites;
•Eldercare Locator (AoA);
•DSHS End Harm campaign and the activities associated with the annual statewide July Adult Abuse Prevention month.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Reports of the abuse, abandonment, neglect, financial exploitation or self-neglect of a participant are received by Adult Protective Services by phone, fax, letter, or in-person.

When indicated, APS will summon an appropriate emergency resource during intake (e.g., law enforcement when a crime against a person or property is in progress; emergency medical services when the vulnerable adult is in need of immediate medical assistance; or a mental health agency when the vulnerable adult is threatening to harm self or others or cognitive impairment is so severe that it is unsafe to be alone).

Each intake report is reviewed and preliminary information is gathered in order to determine if APS has jurisdiction; whether the allegations will be investigated by APS; and the time frame for initiation of each investigation.

Based on the facts and circumstances known at intake, reports are prioritized and assigned for investigation based on the severity and immediacy of actual or potential physical, mental or financial harm to the alleged victim, as follows:
•"High" priority when serious or life threatening harm is occurring or appears to be imminent.
-APS will conduct an unannounced private interview with the alleged victim within 24 hours of receipt of the report.
•"Medium" priority when harm that is more than minor, but does not appear to be life threatening at this time, has occurred, is on going, or may occur.
-APS will conduct an unannounced private interview with the alleged victim within 5 working days of receipt of the report.
•"Low" priority when harm that poses a minor risk at this time to health or safety, has occurred, is ongoing, or may occur.
-APS will conduct an unannounced private interview with the alleged victim within 10 working days of receipt of the report.

On a case-by-case basis, the APS supervisor or designee may specify a specific response time shorter than the maximum response time designated for the priority level.

APS investigations are completed within 90 days of assignment unless necessary investigation or protective services activity continues. If a case remains in "investigating" or "investigation pending" status 90 days after intake, APS supervisors review the case at least every 30 days thereafter for the duration of the case.

The participant or the participant's representative is informed of the results of the investigation verbally and, if requested, will receive a redacted copy of the report. For unsubstantiated results the participant/representative receives verbal notification at the end of the investigation. For substantiated results, the participant receives verbal notification (written when requested) at two stages throughout the investigation; (1) when a determination by the investigator to recommend that the allegation be substantiated and (2) when this determination has been reviewed by

the regional reviewing authority.

References:

oRCW 74.34: Abuse of Vulnerable Adults statute
oWAC 388-71-0100 through 01280: Adult Protective Services
oHCS Long-Term Care Manual, Chapter 6, policies and procedures of the Adult Protective Services Program

e. Responsibility for Oversight of Critical Incidents and Events. Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

Adult Protective Services is a state wide program within the single state Medicaid agency. The intakes, investigations and protective services performed by APS are continuously monitored at both the state and the regional levels.

For example:
oRegional supervisors and program managers conduct on-going quality assurance audits of APS case records.

oThe APS program has implemented a new statewide QA monitoring process that includes record reviews and a formal in-person skills evaluation conducted by a supervisor during an actual APS investigation.

oSeveral reports based on data pulled from the statewide APS data base are routinely generated and evaluated no less than annually by program managers and upper management at the state office.

oThe regions have and use a report system tool that enables them to create customized reports pulled from the statewide data base to track, monitor and evaluate implementation of APS in their region.

oAPS also routinely reports some aspects of program performance to the Governor for review (Government Management Accountability and Performance).

oData is used to develop statewide training for case managers and the community on adult protective services and how to recognize and prevent instances or re-occurances of abuse, neglect and exploitation.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 2)

a. Use of Restraints or Seclusion. *(Select one)*:

◉ **The State does not permit or prohibits the use of restraints or seclusion**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints or seclusion and how this oversight is conducted and its frequency:

The Medicaid Agency through the Aging and Disabiliy Services Administration is responsible for detecting the unauthorized use of restraints or seclusion.

Required training for all paid caregivers includes clear instructions that any use of seclusion or restraint is prohibited. Caregivers are among the people that Washington State Law (RCW 74.34) lists as mandatory reporters of suspected abuse. Mandatory training includes detailed information on types of prohibited restraint (physical, chemical, environmental), risks related to the use of restraints, and alternatives to the use of restraints.

The Medicaid Agency detects use of restraint and seclusion through reports received in the Adult Protective Services system, through the face to face CARE assessment process conducted yearly and at significant change, through the grievance process and through quality assurance activities that may include face to face interviews of clients and review of complaints.

Participants have the authority to hire and fire at any time providing an additional protection.

- **The use of restraints or seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

  i. **Safeguards Concerning the Use of Restraints or Seclusion.** Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints or seclusion). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

  ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of restraints or seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 2)

b. Use of Restrictive Interventions. *(Select one)*:

- **The State does not permit or prohibits the use of restrictive interventions**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

The Medicaid Agency through the Aging and Disabiliy Services Administration is responsible for detecting the unauthorized use of restrictive interventions.

Required training for all paid caregivers includes clear instructions that any use of restrictive intervention is prohibited. Mandatory training includes detailed information on types restrictive interventions that are beyond the obvious use of restraint and seclusion. Training also includes multiple alternatives to restrictive intervention and instructs the caregiver to consult with others involved in the person's care such as family and case managers.

The Medicaid Agency detects use of restrictive intervention through reports received in the Adult Protective Services system, through the face to face CARE assessment process conducted yearly and at significant change, through the grievance process and through quality assurance activities that may include face to face interviews of clients and review of complaints.

Participants have the authority to hire and fire their personal care provider at any time.

- **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

  i. **Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

  ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

- **No. This Appendix is not applicable** *(do not complete the remaining items)*
- **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

Answers provided in G-3-a indicate you do not need to complete this section

i. Provider Administration of Medications. *Select one:*

- **Not applicable.** *(do not complete the remaining items)*
- **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

iii. Medication Error Reporting. *Select one of the following:*

- **Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**
  Complete the following three items:

  (a) Specify State agency (or agencies) to which errors are reported:

  (b) Specify the types of medication errors that providers are required to *record:*

  (c) Specify the types of medication errors that providers must *report* to the State:

- **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

  Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare
The State, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.

i. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percent of APS investigations completed within mandatory timeframes: Numerator: Number of completed APS investigations completed within mandatory timeframes Denominator: Number of APS complaints investigatons

Data Source (Select one):
Other
If 'Other' is selected, specify:
Administrative Data

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**

☑ **Other** Specify: 6 months statewide analysis

Performance Measure:
Number and percent of critical incidents requiring investigation, by type Numerator: Number of critical incidents requiring investigation by type Denominator: Number of critical incidents reported by type

Data Source (Select one):
Other
If 'Other' is selected, specify:
Administrative Data

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: 18	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

☐ **Continuously and Ongoing**
☑ **Other** Specify: 6 month statewide analysis

Performance Measure:
Percent and number of critical incidents substantiated by type Numerator: Number of critical incidents substantiated, by type Denominator: Number of critical incidents investigated, by type

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

	☐ **Continuously and Ongoing**
	☑ **Other** Specify: 6 month statewide analysis

Performance Measure:
Percent of critical incidents that should have been reported Numerator: Number of records reviewed where a referral for APS/CPS was required and not completed Denominator: Number of records reviewed

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**

☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: 12 months

Performance Measure:
Percent of records reviewed where nursing referral is triggered and referral is made N: Number of records reviewed where nursing referral is triggered and made (or appropritae justification for not referring is idenitified) D: Number of records reviewed where nursing referral is triggered

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: 18 months	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**

☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

ADSA has strong systems in place to address this assurance and to protect vulnerable adults in home and community settings from critical incidents and other life-endangering situations. The Quality Management Strategy for ensuring compliance with the Health and Welfare Assurance includes prevention training; community education and participation; continuous access to reporting, data collection, analysis, and policy review; monitoring provider actions taken when substantiation of abuse, neglect, abandonment or exploitation are found; monitoring, evaluation and actions taken by ADSA when required; investigation by law enforcement, adult protective services, residential care services and children's protective services for allegations of abuse, neglect, abandonment or exploitation.

Adult protective service supervisors monitor four investigation records per experienced investigator per year and complete one observation of an interview. For new staff, supervisors monitor the first ten investigations assigned, then five others throughout the year along with two interview observations within the first year of hire. Corrections are expected if appropriate and are verified by the supervisor. ADSA program managers at headquarters monitor a statistically valid sample of cases that have either been screened out or have been closed because they do not meet state statutory parameters for APS.

Adult protective services reports can be accessed in a variety of ways. Standard reports created by the Forecasting and Data Analysis unit are made available to all of ADSA. Ad hoc management reports, available from the ADSA website, can be customized and created upon demand through the APS automated system. These reports are available on a three level hierarchy of access: an individual APS worker may access reports about his/her own cases; APS supervisor/manager access reports about his/her own region, units, and workers; ADSA headquarters access reports about all individual workers, units, regions, and statewide. These reports are used for on-going evaluation to ensure that appropriate actions are taken in addition to the analysis of abuse, neglect and exploitation trends, and to facilitate day-to-day workload management.

The consultant and/or case manager documents and addresses health/safety interventions for waiver participants such as: PERS (Personal Emergency Response system), evacuation in an emergency, minimum consultant contacts, environmental modifications, client training, skin observation protocol, nursing referral indicators from triggered referral screen, assistance obtaining durable medical equipment, cognitive deficits, person(s) responsible for supervising caregivers, screen to document client falls, drug/alcohol assessments, depression screening, caregiver burnout, suicide risk, and other high risk indicators.

HCS/AAA Nursing services RNs respond to referrals by case managers based on nursing indicators identified in CARE. Nurses document nursing services activities in CARE and collaborate with case managers on follow up recommendations.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

Adult protective services and are reviewed by individuals at each level (investigator, supervisor/manger, program manager, executive management) who decide on individual and systemic levels what, if any, corrections and improvements are needed. Reports to other licensing/certification agencies are made if needed.

RCW 74.34.300 allows the State to conduct vulnerable adult fatality reviews. The State may convene a fatality review when the department receives notice of a vulnerable adult's death and the department has reason to believe that the death is related to abuse, abandonment, neglect, or self-neglect, or exploitation, and the vulnerable adult was receiving home and community-based services in his or her own home, described under chapters 74.39 and 74.39A RCW, within sixty days preceding his or her death; or living in his or her own home and was the subject of a report under this chapter received by the department within twelve months preceding his or her death. The fatality review process is completed within 60 calendar days from the date the fatality review was assigned for action.
Remediation for nursing services includes making individual corrections if appropriate when it is determined that a referral to nursing services should have been made or follow up was not completed within time frames. Each record is reviewed during the supervisory and quality assurance review cycle to determine if a mandatory referral to adult protective services or the residential complaint resolution unit should have been made. If appropriate, the consultant or case manager is expected to make necessary corrections. Corrections are verified by either the QA team or the consultant or case management supervisor. Reports and aggregate data are reviewed at all levels by individuals that make decisions on what improvements are needed individually or systemically and what actions should be taken. CSS and the case management entity is required to develop corrective action plans to address any area where proficiency was less than 100%. Draft plans are reviewed by ADSA prior to approval and implementation. Progress reports are produced every six months which are reviewed and action is taken if needed. Systemic issues are addressed in on-going training, policy review/revision/development, and other areas as needed.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: 18 months

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

- ◉ **No**
- ○ **Yes**

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial

accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QMS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the QMS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QMS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

Ongoing discovery and remediation is facilitated by regular reporting and communications among ADSA QA

team, Home & Community Programs, State Unit on Aging, State regional offices, Area Agencies on Aging, and other stakeholders including service providers and agencies. ADSA is the entity responsible for trending, prioritizing and determining system improvements based on the data analysis and remediation information from the ongoing quality improvement strategies. These processes are supported by the integral role of other waiver partners in providing data, which may also include data analysis, trending and the formulation of recommendations for system improvements. These partners include Waiver Service Providers, Adult Protective Services, Social Service Payment System, Health and Recovery Services Administration, Mental Health Division, Division of Developmental Disability, Department of Health, Area Agencies on Aging, Contracted Financial Management Services, Contracted Consultant Support Services, and participants.

ADSA analyzes and trends data received from QA/QI activities and waiver partners. When data analysis identifies areas needing improvement, ADSA along with waiver partners, develop remediation strategies. Strategies are prioritized and change is implemented based on ADSAs strategic goals and available resources.

Plans developed as a result of this process are shared with stakeholders for review and recommendations. Regular reporting and communication among waiver partners facilitate ongoing discovery and remediation.

ii. System Improvement Activities

Responsible Party *(check each that applies):*	**Frequency of Monitoring and Analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Quality Improvement Committee**	☑ **Annually**
☑ **Other** Specify: AAA, CSS, FMS	☑ **Other** Specify: 18 months

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

The QA monitoring system is an integral part of the discovery process and integrates the CMS quality framework and QA assurances. New Freedom monitoring is a component of the overall monitoring process. Data/reports produced from the QA process and CARE are key components of the overall Quality Management Strategy and are used for quality assurance/quality improvement activities or remediation.

The State Medicaid quality assurance team reviews local monitoring activities during the HCS/AAA monitoring cycle. For experienced staff, reports are produced for analysis and action. Monitoring records are reviewed to ensure new staff monitoring is occurring.

Consultant Support Services (CSS) and Financial Management Services (FMS) complete internal monitoring and quality control procedures for all participants. Summary information related to these activities such as home visits, phone calls, or audits are provided to ADSA quarterly. The State Medicaid quality assurance team reviews CSS and FMS tracking of participant budgets, participant contacts, and access to waiver goods and services.

CSS provides ADSA with quarterly reports that include the number of new PCSP's and number/hours of participant contact; quality assurance tracking reports to include the number of days from authorization/enrollment (SSPS begin date) to completion of the PCSP, and receipt of goods and services.

FMS provides expenditures and budget monitoring reports monthly to CSS and ADSA, and quarterly to participants. Reports are reviewed to ensure that budgets are not overspent or services are not underutilized.

FMS and CSS provide complaint/Grievance summary report and annual satisfaction survey summaries directed to participants', IP's and other vendors.

The ADSA QA team is responsible for monitoring program eligibility, accuracy and quality of file documents, and if policy & procedures, state and federal statutes including waiver requirements are met. The QA team monitors six state regional areas and 13 Areas on Aging, and the contracted case management entity each review cycle (every 18 months. Follow up is done to verify that corrections have been made to critical areas (health & safety, eligibility, payment). Remediation plans are reviewed and approved to ensure all required issues have been addressed.

ADSA QA team is also responsible for oversight of CSS and FMS operations including implementation and compliance with contract requirements, state and federal laws and regulations, policies and procedures; approval and oversight of fee for service rates, billing for services provided, review of remediation (corrective action) plans; and review of utilization reports submitted by CSS and FMS.

QA Team Monitoring Process includes a review of a statistically valid sample. The State Medicaid quality assurance team uses a statistically valid sample with a confidence level of 5% to monitor CARE assessments. A random sample is pulled and monitored over a statewide18 month review cycle. New Freedom participant monitoring includes elements related to waiver eligibility and level of care.

ADSA QA team monitors CSS and FMS operations on alternate years in the following areas: Level of care evaluation, review of participant service plans, prior authorization of waiver services, utilization management, qualified provider enrollment, execution of Medicaid provider agreements, quality assurance and quality improvement activities

During the 18 month review cycle each of the 19 offices and the contracted case management entity is monitored based on an established schedule. Because of the time needed to complete a local review, overlap occurs. While one area is working on remediation and development of a corrective action plan, the monitoring begins in another location (i.e.: pulling a random sample and completing initial reviews). This ensures all areas are completed within the 18 month timeframe.

The QA team uses a standardized monitoring process which includes:
• Pulling a random statistically valid sample and completing an initial review
• Meeting with the local management team, QA Program Manager, AAA lead and AAA liaison, New Freedom case management team, and the HCS Deputy Director as appropriate to review preliminary reports and discuss next action steps
• Verifying remediation which is required at the individual level for areas identified
• Providing final reports for analysis and action
At the completion of each office's monitoring, data is analyzed and used to develop local corrective action plans, policy /procedural changes and training or guidance at the regional/AAA/case management entity, unit, and/or worker level. Ongoing analysis of data is reviewed. If a trend becomes evident after reviewing several offices, action is taken at the headquarters level without waiting for the completion of the review cycle

Upon completion of the review cycle, statewide systemic data is analyzed for trends and patterns by managers, the ADSA Clinical Effectiveness and Performance Improvement Unit (CEPI) and executive staff. The CEPI unit conducts research into methods of improvement and training which are also incorporated into quality improvement activities. Decisions for action are made based on analysis and prioritization. These activities may include statewide training initiatives, policy and/or procedural changes and identification of quality improvement activities/projects.

Home and Community Programs (HCP) is responsible for development of policy and procedures related to HCS quality assurance/improvement activities, oversight of assessment, service planning and delivery models, monitoring compliance to Home and Community Programs (HCP), including HCBS. HCP monitors for irregularities in waiver or other payment authorizations through on-going review of Social Service Payment System (SSPS) reports. CARE generated reports are reviewed for program compliance and eligibility criteria; investigation of complaints or inquiries from the field staff, Medicaid fraud Control Unit, Payment Integrity unit, ADSA budget unit, constituents, legislative staff and other DSHS entities; review of various reports regarding the daily operation of the Home & Community programs; program review and eligibility consultation to supervisors and field staff; policy briefings and program updates for QA staff; social worker and case manager training; considers requests for additional personal care hours to meet exceptional need.

Program Managers within the State Unit on Aging and Home and Community Programs are responsible for

analyzing various QA team and CARE regional and statewide reports related to their programs to identify needed policy changes/clarifications, areas of improvement, and training.

Office chiefs for the State Unit on Aging and HCP are responsible for analyzing the results of regional and statewide reports related to programs administered by Home and Community Services to identify and prioritize policy changes/clarifications, performance improvement activities, and training.

Clinical Effective and Performance Improvement (CEPI) Unit measures the effectiveness of assessment, care planning and interventions and recommends performance improvements. CEPI focuses on clinically effective performance measures and uses these measures to inform, design and develop methods to fully involve and empower recipients in managing their health outcomes, long-term care services and chronic illness; clinical competencies and training; clinical outcomes; long term care practice policy; and program delivery systems.

Adult Protective Services (APS) is responsible for investigating and making official findings on any accusations of abuse, neglect or exploitation of a vulnerable adult, who does not live in either a licensed setting or is served by a certified residential service. Local and statewide reports are available and reviewed by APS headquarters managers and field managers.

AAAs are responsible for discovery and remediation activities related to waiver provider contracts. AAAs monitor their four year Area Plan annually and create an area plan update to address issues identified.

HCS and AAA supervisors are responsible for monitoring at a minimum, four records per worker per year (approximately 2500 statewide annually) to ensure accuracy of annual LOC determinations. Level of Care and service plans are reviewed and updated annually or at significant change. For new staff, a minimum of 50% of LOCs are reviewed during the first six months of employment. The number of reviews completed varies depending on staff turnover. Data for new staff is not collected in the formal monitoring application. Errors in assessment that can lead to an inaccurate eligibility determination, health and safety or payment issues are corrected immediately.

CSS and FMS are responsible for internal monitoring and quality control procedures to track New Freedom participants, PCSP implementation, participant contacts, and access to waiver services. Quarterly reviews of the implementation of the PCSP are completed and include elements related to health and safety, satisfaction, adequacy of the current plan and the possible need for revisions. PCSPs are reviewed following each major update and at least annually thereafter.

ADSA monitors CSS to verify that CSS is:
• Assisting the Participant to develop a PCSP that identifies a range of services/goods that will provide them the level of support and flexibility they desire within their budget resources.
• Reviewing the Participant Service Budget (PSB) received from the FMS monthly to ensure that the Participant is receiving the services/goods identified in their PCSP in a timely manner.
• Making contact with the Participant at least quarterly to make any changes that may be needed to the PSB.

• Coordinating with contracted case management entity when there is an identified significant change with the participant care needs that would warrant a reassessment in CARE or when budget changes occur.
• Developing and implementing systems to obtain participants' feedback on satisfaction with services and to monitor the program's effectiveness in achieving the preferred outcomes.
• Assisting and training participants, as requested, in recruiting, screening, hiring, training, scheduling, communicating expectations, and monitoring IP work functions.
• Responding to complaints received about CSS within 10 days of receipt. CSS notifies ADSA if a complaint cannot be resolved or is reoccurring.
• Soliciting annual feedback from participants regarding Contractor performance of CSS on their behalf.
• Reviewing and responding to Quality Assurance tracking reports that include the number of days from authorization/enrollment (SSPS begin date) to completion of the PCSP, and receipt of care services
• Developing and implementing an internal quality assurance plan.

ADSA monitors FMS to verify that FMS is:
• Managing all financial and contract matters on behalf of the participant
• Executing and managing contracts with qualified waiver providers
• Establishing payment processes associated with the PCSP
• Developing policies and procedures that address the philosophy of participant directed services.
• Providing individual service budget reports monthly to CSS and quarterly to Participants

At a local level, effectiveness of system change is also evaluated continuously and measured at each QA team review cycle. Comparison monitoring reports measure whether a region/AAA or the contracted case management entity declined, stayed the same, or improved from the previous review cycle.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The Quality Improvement Strategy is evaluated and adjusted prior to the beginning of a review cycle and each waiver renewal. Workgroups consisting of ADSA HQ program managers, Home and Community Services and Area Agency on Aging Supervisors, case managers, and nurses evaluate the QA strategy/program. Modifications/expectations are made based on changes in federal or state rules and regulations, ADSA policy and procedures, CMS assurances, input from participants, providers, and data from various reports including recommendations from the previous review cycle.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Records retained at the consultant and financial management agencies provide the necessary documentation to ensure the integrity of payment made for waiver services. The case records at the consultant agency contain the recipient's eligibility documents, spending plan and other information regarding the recipient's needs. The financial management agency is required to maintain documentation that the provider qualifications have been verified and that expenditures are in accordance with the spending plan. Source documentation is required for all expenditures, along with monthly accounting of expenditures and monthly accounting of client account balances. The documentation must be maintained a minimum of five years from the claim date and must be available for audit or review upon request.

The financial management agency obtains an annual independent audit. ADSA provides periodic monitoring of The FMS documentation and accounting systems. Monitoring includes tracking of expenditures to source documents, assessing accuracy of sample of reports, and agency internal processes and controls.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability
State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.

i. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percentage of clients for whom inappropriate payments were made after death. N= Number of deceased clients for whom inappropriate payments were made D= Number of deceased clients

Data Source (Select one):
Other
If 'Other' is selected, specify:
Administrative Data

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**

☐ **Other**
Specify:

Performance Measure:
Percentage of clients for whom the FMS agency is correctly reimbursed. Numerator= Number of clients for which the FMS receives monthly payment Denominator= Number of clients enrolled in the waiver in the month.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Administrative Data

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other**	☐ **Annually**

Specify:	
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percentage of clients for whom the CSS agency is correctly reimbursed Numerator= Number of clients for which the CSS receives monthly payment Denominator= Number of clients enrolled in the waiver in the month.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Administrative Data

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**

☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
Billings and payments to both the FMS and CSS are reviewed monthly. Monthly enrollment lists are reconclied against monthly budget authorizations for each enrolled participant. Discrepencies between enrollment lists and budget authorizations are reviewed individually by the New Freedom program manager. Payment to the FMS and CSS is not made by the Department until any discrepencies have been reconciled. Payment adjustments are documented in the Department's Agency Financial Reporting System (AFRS).

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Billings and payments to both the FMS and CSS are reviewed monthly. Monthly enrollment lists are reconclied against monthly budget authorizations for each enrolled participant. Discrepencies between enrollment lists and budget authorizations are reviewed individually by the New Freedom program manager. Payment to the FMS and CSS is not made by the Department until any discrepencies have been reconciled. Payment adjustments are documented in the Department's Agency Financial Reporting System (AFRS).

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: 18 months

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

- (●) **No**
- ( ) **Yes**

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

Rate determinations are the responsibility of DSHS/ADSA and based on appropriations of the Washington State Legislature. ADSA uses the CARE tool, an automated system used to collect demographic data, assess functional needs and abilities, health, and medical information, determine eligibility for services, develop a care plan, and authorize services for clients receiving or requesting long-term care services.

ADSA, through CARE, employs a client classification methodology consisting of seventeen care groups. Twelve groups apply to clients served in residential and in-home settings. For the in-home setting, two additional exceptional care groups apply.

The CARE software program evaluates information about the client based on major predicators of direct care need: clinical complexity, cognitive impairment, behavioral support needs and activities and incidental activities of daily living. CARE uses computerized formulas, or algorithms to place clients in a classification group based on the assessment and assign base hours.

The base hours are adjusted to account for informal support, paid by individual(s) or group(s) other than ADSA and support shared living circumstances. CARE determines the adjustment by placing a numeric value on the amount of assistance available to meet the client's needs and reduces the base hours assigned to the classification group using assigned values for each specific ADL and IADL.

The rate determination process is established in the Washington Administrative Code (WAC) that contains the rules and regulation used to determine eligibility, payment rates, etc. ADSA followed the Administrative Procedure Ac t (APA) RCW 34.05, inclusive of established mechanisms for public comment and input on the rates process, when adopting the new regulation contained in chapter 388-72A WAC, Comprehensive Assessment and Reporting Evaluation Tool.

The New Freedom waiver will use base hours as determined by CARE as the basis of the participant's monthly budget for services. The New Freedom waiver will use base hours to be paid as determined by CARE as the basis of the participant's monthly budget for services. The individual budget amount is calculated after the waiver participant is assigned a classification resulting from completion of the comprehensive assessment reporting and evaluation tool, CARE. The calculation is based on the published hourly rate for individual provider personal care paid by the department multiplied by the number of hours generated by the assessment, multiplied by a factor of .95, plus an amount equal to the average per participant expenditures for non-personal care supports purchased in the COPES waiver. The average is recalculated in July of each year.

Personal Care rate determinations are the responsibility of DSHS/ADSA and based on appropriations of the Washington State Legislature. Rates are negotiated between the union representing home care workers and the Governor's office. Legislative approval and appropriation is required following agreement between the parties.

For waiver services other than personal care, the FMS and the participant negotiate rates that are within the prevailing charges in the locality for comparable services under comparable circumstances and that are reasonable and consistent with market rates.

Waiver participants are informed by the CSS about all payment rates prior to authorizing service expenditures. In addition, rates for Individual Providers and Agency Providers of personal care are publically available on the ADSA web site.

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Waiver services are processed by the fiscal management agency. The agency maintains data on waiver recipients including recipient name, birth date, social security number and case number. The recipient data is associated with the provider name, provider payment identification number, waiver service begin and end dates, rates and authorization information that is based on the clients spending plan.

An invoice from an authorized provider is the basis for payment of waiver services which have been provided. Each service is shown on an invoice one time each month it was authorized as the month ends. A service will not be shown on an invoice a second time unless the fiscal management services re-authorizes payment. The signed invoice is verification the service has actually been provided. Payments are made directly to the service provider. Historical records of all payments are maintained for a minimum of 5 years.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one)*:

- ◉ **No. State or local government agencies do not certify expenditures for waiver services.**
- ○ **Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

***Select at least one*:**

☐ **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).*(Indicate source of revenue for CPEs in Item I-4-a.)*

☐ **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

Payment for services identified in the spending plan will be authorized when the following are satisfied:
1.Categorical relatedness and financial eligibility are approved
2.The participant is eligible for nursing facility level of care and is, or likely to be institutionalized
3.The individual spending plan has been signed by the participant and consultant
4.The service provider is qualified
5.The participant verifies that service was provided

e. Billing and Claims Record Maintenance Requirement. Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS (*select one*):

- **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- **Payments for some, but not all, waiver services are made through an approved MMIS.**

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- **Payments for waiver services are not made through an approved MMIS.**

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Payment to the fiscal management agency is made through the Department’s Medicaid social service payment system. Payment to the FMS is based on the the clients assessed rate category and that payment is the basis for the federal draw.

The SSPS maintains data on waiver recipients including recipient name, birth date, social security number and case number. The recipient data is associated with the provider name, provider payment identification number, waiver service begin and end dates, unit rate, authorized service charge code, amount paid, date paid, etc.

The Financial Management Services agency authorizes waiver service payments for Individual Providers (IP) of personal care using a DSHS 14-154, Service Authorization form. Information on the form is used to update the SSPS computer database. A copy of the completed form is retained in the recipient’s case record and the service provider receives a notice of payment authorization from SSPS. The computer generates a Change of Service

Authorization form (DSHS 14-159) after the first authorization is processed. The FMS uses this Change of Service form to add, change, or terminate services.

The Service Invoice is the basis for payment the personal care, which have been provided by the IP. Each service is shown on an invoice one time for each month it was authorized as that month ends. Even if a service has not been billed or paid for, it will not be shown on an invoice a second time unless the FMS re-authorize payment. The provider signs the invoice and returns it to the department. Payments are made directly to the service provider. Historical records of all payments are maintained.

○ **Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

☐ **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**

☑ **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**

☑ **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

The contracted Financial Management Services agency makes payments directly to providers of each waiver service with the exception of personal care provided by Individual Providers. Payment for personal care provided by Individual Providers is authorized by the FMS through the State Social Service Payment System (SSPS).

The FMS is responsible for developing contracts with vendors, implementing efficient and timely consumer directed payment systems and facilitating payment for labor, services and other items needed by participants as identified in the PCSP.

ADSA QA team is responsible for oversight of FMS operations including implementation and compliance with contract requirements, state and federal laws and regulations, policies and procedures; approval and oversight of fee for service rates, billing for services provided, review of remediation (corrective action) plans; and review of utilization reports submitted by the FMS.

ADSA monitors FMS to verify that FMS is:
• Managing all financial and contract matters on behalf of the participant
• Executing and managing contracts with qualified waiver providers
• Establishing payment processes associated with the PCSP
• Developing policies and procedures that address the philosophy of participant directed services.
• Providing individual service budget reports monthly to CSS and quarterly to Participants

Information on becoming a contracted medicaid provider and billing the Medicaid agency directly is available through the local Area Agency on Aging.

☐ **Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

◉ **No. The State does not make supplemental or enhanced payments for waiver services.**

○ **Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to State or Local Government Providers. *Specify whether State or local government providers receive payment for the provision of waiver services.*

◉ **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.

○ **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish: *Complete item I-3-e.*

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

Answers provided in Appendix I-3-d indicate that you do not need to complete this section.

- **The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- **No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as**

provided in 42 CFR §447.10(e).

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- **No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

- **The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- **The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- **This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one*:

- **Appropriation of State Tax Revenues to the State Medicaid agency**

☐ **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

☐ **Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2- c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One*:

◉ **Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.

○ **Applicable**

Check each that applies:

☐ **Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and /or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2- c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one*:

- (●) **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**
- ( ) **The following source(s) are used**

  Check each that applies:
  - [ ] **Health care-related taxes or fees**
  - [ ] **Provider-related donations**
  - [ ] **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

- (●) **No services under this waiver are furnished in residential settings other than the private residence of the individual.**
- ( ) **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:
Do not complete this item.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- (●) **No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- ( ) **Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method

used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- (●) **No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- ( ) **Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- [ ] **Nominal deductible**
- [ ] **Coinsurance**
- [ ] **Co-Payment**
- [ ] **Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

- (●) **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- ( ) **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2d have been completed.

Level(s) of Care: Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	14358.13	6743.00	21101.13	28709.00	5750.00	34459.00	13357.87
2	14313.30	7417.00	21730.30	30145.00	6325.00	36470.00	14739.70
3	14308.21	8159.00	22467.21	31652.00	6957.00	38609.00	16141.79
4	14314.37	8975.00	23289.37	33234.00	7653.00	40887.00	17597.63
5	14313.87	9872.00	24185.87	34896.00	8418.00	43314.00	19128.13

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Number Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		Nursing Facility
Year 1	800	800
Year 2	1281	1281
Year 3	2051	2051
Year 4 (renewal only)	3283	3283
Year 5 (renewal only)	5256	5256

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

Because the New Freedom waiver has just completed the initial pilot period and enrollment was slower than anticipated, the average length of stay is based on historical data from the COPES waiver, reference number 0049. Waiver 0049 serves a similar target population. The estimate is based on the calculation of the total number of enrolled days divided by the unduplicated number of waiver participants.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

Factor D :
A. Cost
2% increase per year for
Personal Assistance Services, Environmental and Vehicle Modifications, Individual Directed Goods, Services and Supports,
Training and Education, Treatment and Health Maintenance.

B. Population
Annual increase of 4% for each of the 5 waiver years.

ii. Factor D' Derivation. The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor D' is calculated by applying a 10 % growth in medical expenses (based on historical data) to the data from the most recent CMS 372 report for each waiver year.
The base data for the projection of Factor D' are expenditures for services provided from 2/1/08 – 1/31/09.

Medicare Part D was implemented 1/1/06, and dual eligibles were automatically enrolled in Medicare Part D. Expenditures for prescription drugs covered under Medicare Part D therefore are not in the base data, so there was no need to remove such costs.

iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G is calculated by applying a 5% growth in nursing facility services costs to the data from the most recent CMS 372 report for each waiver year.

iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G' is calculated by applying a 10 % growth in medical expenses (based on historical data) to the most recent CMS 372 report for each waiver year.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

Waiver Services
Personal Assistance Services (PAS)
Environmental and Vehicle Modifications
Individual Directed Goods, Services and Supports
Training and Educational Supports
Treatment and Health Maintenance

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Assistance Services (PAS) Total:						**9859521.50**
Personal Assistance Services (PAS)	day	785	290.00	43.31	**9859521.50**	
Environmental and Vehicle Modifications Total:						**23380.50**
Environmental and Vehicle Modifications	job	13	50.00	35.97	**23380.50**	

Individual Directed Goods, Services and Supports Total:						**1433742.60**
Individual Directed Goods, Services and Supports	each	493	74.00	39.30	**1433742.60**	
Training and Educational Supports Total:						**3402.90**
Training and Educational Supports	each	5	57.00	11.94	**3402.90**	
Treatment and Health Maintenance Total:						**166456.95**
Treatment and Health Maintenance	each	165	79.00	12.77	**166456.95**	
				GRAND TOTAL:		**11486504.45**
				Total Estimated Unduplicated Participants:		**800**
				Factor D (Divide total by number of participants):		**14358.13**
				Average Length of Stay on the Waiver:		290

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Assistance Services (PAS) Total:						**15740405.40**
Personal Assistance Services (PAS)	day	1257	290.00	43.18	**15740405.40**	
Environmental and Vehicle Modifications Total:						**35860.00**
Environmental and Vehicle Modifications	job	20	50.00	35.86	**35860.00**	
Individual Directed Goods, Services and Supports Total:						**2288147.34**
Individual Directed Goods, Services and Supports	each	789	74.00	39.19	**2288147.34**	
Training and Educational Supports Total:						**5430.96**
Training and Educational Supports	each	8	57.00	11.91	**5430.96**	
Treatment and Health Maintenance Total:						**265496.88**
Treatment and Health Maintenance	each	264	79.00	12.73	**265496.88**	
				GRAND TOTAL:		**18335340.58**
				Total Estimated Unduplicated Participants:		**1281**
				Factor D (Divide total by number of participants):		**14313.30**
				Average Length of Stay on the Waiver:		290

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Assistance Services (PAS) Total:						**25194666.40**
Personal Assistance Services (PAS)	day	2012	290.00	43.18	**25194666.40**	
Environmental and Vehicle Modifications Total:						**57376.00**
Environmental and Vehicle Modifications	job	32	50.00	35.86	**57376.00**	
Individual Directed Goods, Services and Supports Total:						**3659875.72**
Individual Directed Goods, Services and Supports	each	1262	74.00	39.19	**3659875.72**	
Training and Educational Supports Total:						**8825.31**
Training and Educational Supports	each	13	57.00	11.91	**8825.31**	
Treatment and Health Maintenance Total:						**425398.41**
Treatment and Health Maintenance	each	423	79.00	12.73	**425398.41**	
				GRAND TOTAL:		**29346141.84**
				Total Estimated Unduplicated Participants:		**2051**
				Factor D (Divide total by number of participants):		**14308.21**
				Average Length of Stay on the Waiver:		290

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4 *(renewal only)*

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Assistance Services (PAS) Total:						**40346528.40**
Personal Assistance						

Services (PAS)	day	3222	290.00	43.18	40346528.40	
Environmental and Vehicle Modifications Total:						91443.00
Environmental and Vehicle Modifications	job	51	50.00	35.86	91443.00	
Individual Directed Goods, Services and Supports Total:						5861021.26
Individual Directed Goods, Services and Supports	each	2021	74.00	39.19	5861021.26	
Training and Educational Supports Total:						14256.27
Training and Educational Supports	each	21	57.00	11.91	14256.27	
Treatment and Health Maintenance Total:						680838.59
Treatment and Health Maintenance	each	677	79.00	12.73	680838.59	
				GRAND TOTAL:		46994087.52
				Total Estimated Unduplicated Participants:		3283
				Factor D (Divide total by number of participants):		14314.37
				Average Length of Stay on the Waiver:		290

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5 *(renewal only)*

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Assistance Services (PAS) Total:						64589507.60
Personal Assistance Services (PAS)	day	5158	290.00	43.18	64589507.60	
Environmental and Vehicle Modifications Total:						147026.00
Environmental and Vehicle Modifications	job	82	50.00	35.86	147026.00	
Individual Directed Goods, Services and Supports Total:						9384594.16
Individual Directed Goods, Services and Supports	each	3236	74.00	39.19	9384594.16	
Training and Educational Supports Total:						22402.71
Training and Educational Supports	each	33	57.00	11.91	22402.71	
Treatment and Health Maintenance Total:						1090146.28
Treatment and Health Maintenance	each	1084	79.00	12.73	1090146.28	
				GRAND TOTAL:		75233676.75

Total Estimated Unduplicated Participants:	**5256**
Factor D (Divide total by number of participants):	**14313.87**
Average Length of Stay on the Waiver:	290